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AUTHOR Van Nostrand, Joan F.; And Others
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ABSTRACT

Characteristics of the expected 55 million elderly Americans in the year 2050 can be predicted with some accuracy. The proportion of elderly blacks will increase, while the ratio of women to men will remain at three to one, with a higher ratio at the higher age levels. Educational levels will also rise significantly. Current information indicates that between 15-25% of the elderly have significant symptoms of mental illness and need assistance in carrying out their daily living tasks. The elderly also have more health problems and use more health services than the general population. In terms of informal support systems or individuals, approximately 75% of the elderly men and 37% of the elderly women live with a spouse. Nearly 41% of the elderly women live alone. Elderly persons have many contacts with their children, and support from children is likely to increase over the next 30 years as the childlessness rate declines. Long-term care efforts continue to have difficulty in coordinating programs with a specific focus on the individual. Public policy must determine how to make the delivery of long-term care services more responsive to the needs of those requiring such care. (Author/NRB)

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The Need for Long Term Care

INFORMATION AND ISSUES

U.S. DEPARTMENT OF HEALTH, EDUCATION & WELFARE
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A CHARTBOOK OF THE FEDERAL COUNCIL ON THE AGING

CG 015204

Long Term Care Committee

The Federal Council on the Aging

Rev. Msgr. Charles J. Fahey
Chairman
Mary Marshall
Jean J. Perdue, M.D.
Members
Muriel Shurr
Staff

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Introduction

Americans are moving towards an important decision about long term care policy. In the next few years the nation must make a major determination about the system responsible for care of frail and vulnerable people. These are people who have physical and/or mental conditions which make them unable to cope with daily living unless they receive assistance for extended periods of time. Most of them are elderly.

Until a few years ago, not enough Americans had taken cognizance of the problems and issues of long term care in any rational way that could lead to a sound program of such care, Federally or locally. In the mid-1960's, when Medicare and Medicaid came into being, long term care was in its infancy. At that time we knew about doctors and hospitals but we did not know very much about how to deal with persons with chronic conditions that could not be cured medically in a day or a week or a month. Medicaid moved into this lacuna and propelled long term care towards acute medical care and institutional care. One result of this is that about 1.2 million elderly Americans are in nursing homes today, some of them unnecessarily, and between 4 and 5 million other elderly persons who need a combination of social and health services are rarely able to find what they need in their communities.

For a variety of reasons, long term care now seems to be on everyone's agenda. There seems to be a national will to do something about it at last.

The Federal Council on the Aging first focused on issues and problems of long term care in 1975. This resulted in the publication of *Public Policy and the Frail Elderly,* which identified a population at risk. Thereafter, the Council's focus on long term care problems resulted in the publication of *Key Issues in Long Term Care: A Progress Report.* The present Chartbook, *The Need for Long Term Care: Information and Issues,* is the third in this series of documents.

These publications have been widely disseminated and will be distributed more widely still in the hope that they may serve to set a national agenda on long term care for the 1981 White House Conference on Aging

scheduled for next December. The goal of all three documents is to help frame the major elements of the debate on long term care so that the 1981 White House Conference delegates can penetrate deeply into the problems of that subject with the least waste of time and dissipation of energies on peripheral issues.

This FCA Chartbook was developed by the Council's Long Term Care Committee with expert advice and assistance from the Work Group and Task Force whose members are given in the appendix. The Council members at their December 1980 quarterly meeting approved the draft for publication. The Chartbook brings together five main streams of information: base-line materials on demographics, health status, use of health services, and informal supports with the focus constantly on elderly Americans. It concludes with a sixth section dealing with Federal policies which impact on the delivery of long term care.

It represents a mosaic of the diverse pieces that must fit into an understanding of the issues and realities of long term care.

The charts and their commentaries shed light on where we were yesterday, show how we got where we are today, and project where we are going now. They point to interrelationships that have important impact on need for long term services—ties between age and disability, education and income, minority status and longevity, living alone and being female.

The Chartbook was prepared with many users in mind but first of all for delegates to the White House Conference on the Aging—the planners and policy makers, legislators, and all others concerned with aging of the American people. The Federal Council on the Aging sincerely hopes they will find it useful and helpful in the important task that stands before them.

Rev. Msgr. Charles J. Fahey
Chairman
The Federal Council on the Aging

I Demographics

I Demographics

Introduction

The future number of the elderly and some of their characteristics can be predicted fairly accurately up to the year 2050, because most of them were already born in 1980.

On the way to expanding from a population of 25 million elderly today to a nation of about 55 million elderly in 2050, America will experience its next major surge in the elderly population between 2010 and 2030. But the country will not undergo as high a growth rate of the elderly population then as it already experienced during the 1950's.

In the decades ahead the proportion of Black elderly persons will increase. The ratio of women to men will remain close to its present high differential—three women to every man at age 65 and over and a much higher ratio at higher age levels. Educational levels will rise significantly.

Since the 1950's, the elderly population has taken major steps away from poverty. But Black elderly and households headed by elderly women made less than average progress.

Issues raised by these data include the following: How do projections of the size of future elderly populations help determine future needs for long term care? What impact will the greater growth rates for Black elderly have on the need for long term care? To what extent does the high ratio of women to men in the elderly population affect the need for long term care? What impact will higher educational attainment have on need? Will reductions in poverty affect the need for long term care?

I How fast is the elderly population growing?

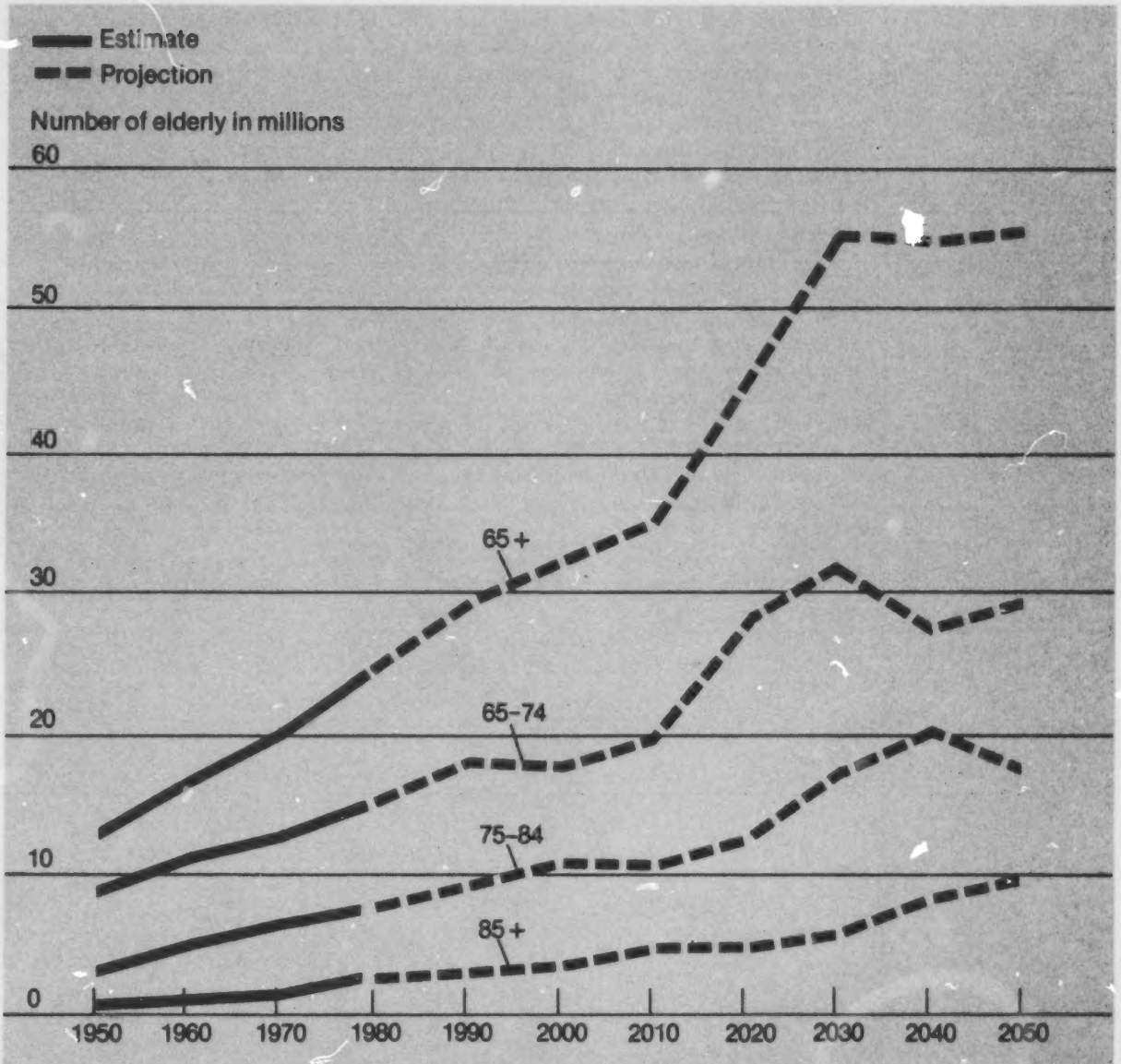
During the 1980's, the number of Americans 65 and over will increase from about 25 million to about 30 million. This 20 percent increase will be only slightly lower than the rate experienced in the 1960's and 1970's.

After 1990, however, the Bureau of the Census projects a changed pattern of growth. The rate of increase in the elderly population between 1990 and 2010 will be slower than in the previous decades. Then the rate of increase will surge explosively between 2010 and 2030 when the baby boom generation becomes elderly. After that, there will be scarcely any increase in the number of elderly from 2030 to 2050. To express this real and projected growth in *numbers* of Americans 65 and over, the 12 million elderly in 1950 became 25 million in 1980 and will become 55 million in 2030.

The major causes of spurts and slow-downs in the growth of the elderly population are, of course, the birth rates when the elderly were born. Increased longevity is another factor. Slower growth expected during the 1990–2010 periods stems from lower birth rates during the depression years of the 1930's and World War II. Similarly, the dramatic increase in elderly population projected between 2010 and 2030 relates to the high birth rate during the post-war baby boom.

Even the tremendous rate of increase in numbers of elderly people between 2010 and 2030 will constitute a lower *rate* of increase in the elderly population than American society already experienced in the 1950's.

Number of elderly by age groups: United States, 1950–2050.
(Chart I.1)



Note: These data represent the entire census level legal population. They do not include any data from the 1980 census.
Source: United States Bureau of the Census. (See References for details.)

I What are the differences in population growth rates by race?

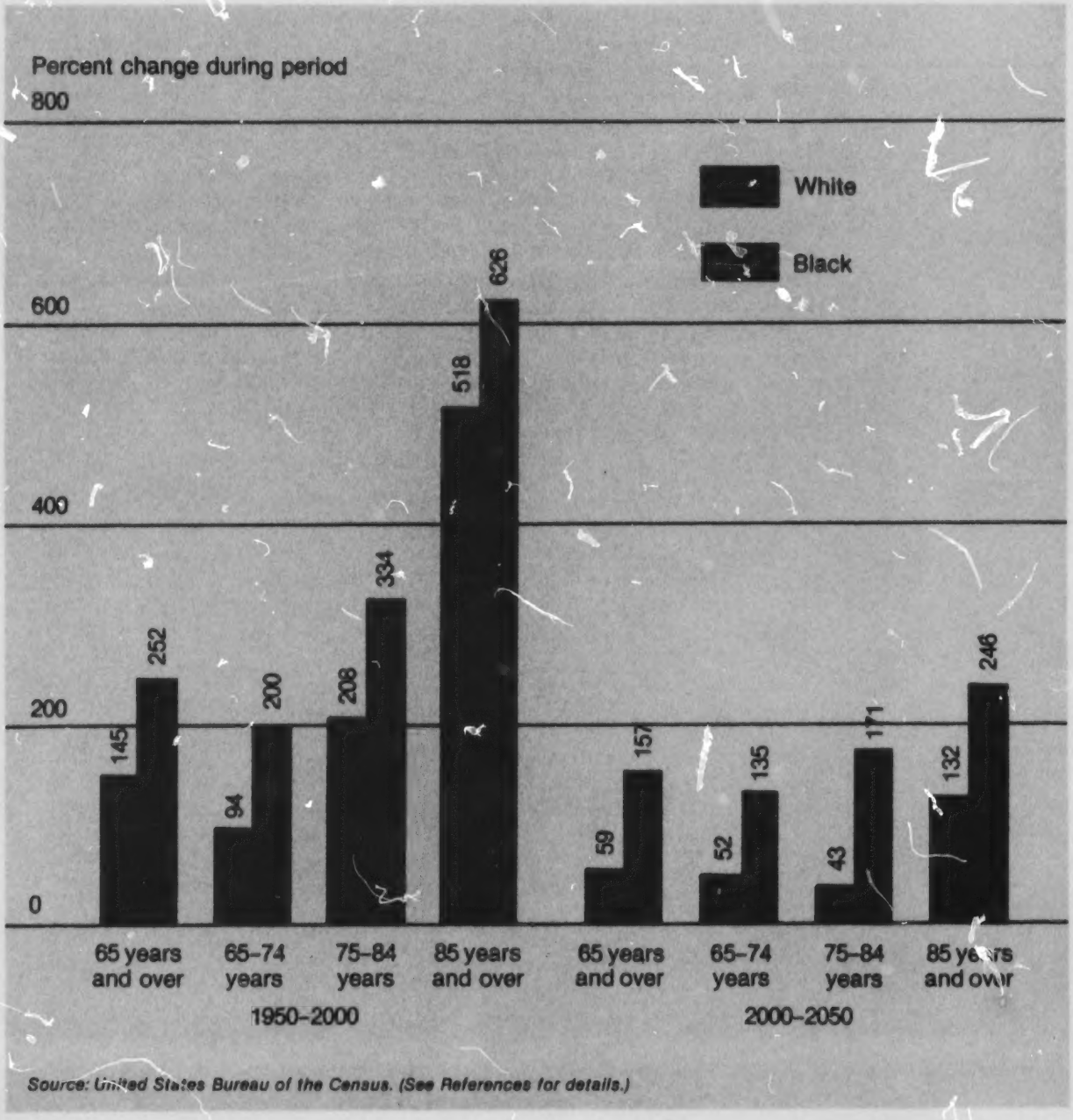
The Black population, both young and old, has grown faster than the White population during the 20th century and can reasonably be expected to continue to do so in the future. This differential is due not only to the higher fertility levels of Black women, but to the more rapid gains in life expectancy experienced by Blacks compared with Whites. Although White children born in 1978 could be expected to outlive Black children by five years if 1978 mortality rates were held constant in the future, this is a vast improvement over the 16-year gap that prevailed at the turn of this century.

The change in number of White and Black elderly persons by age group is presented here for two time periods, 1950–2000 and 2000–2050. In each age group in both periods the number of elderly Blacks is expected to grow more rapidly than Whites. As a result, the proportion of all elderly persons who are Black is expected to rise from 8 percent in 1950 to 11 percent in 2000 and 18 percent in 2050. During both of these 50-year periods, the 85-and-over age group will be the fastest growing age group among the elderly regardless of race. In 1950, only one in every twenty elderly Blacks and Whites was 85 years or older. By 2050, the proportion is projected to be one-sixth for Whites and one-seventh for Blacks.

If this growth is expressed in numbers rather than percentages, the elderly White population will grow by 16.5 million in the later period, almost the same as the increase of 16.7 million in the earlier period. For elderly Blacks, the numerical increase in the later period (4.8 million) is over twice as high as the earlier period (2.2 million).

Percent change in number of elderly by age groups and race: United States, 1950–2000 and 2000–2050.

(Chart I.2)



Source: United States Bureau of the Census. (See References for details.)

I How many more elderly women are there than men?

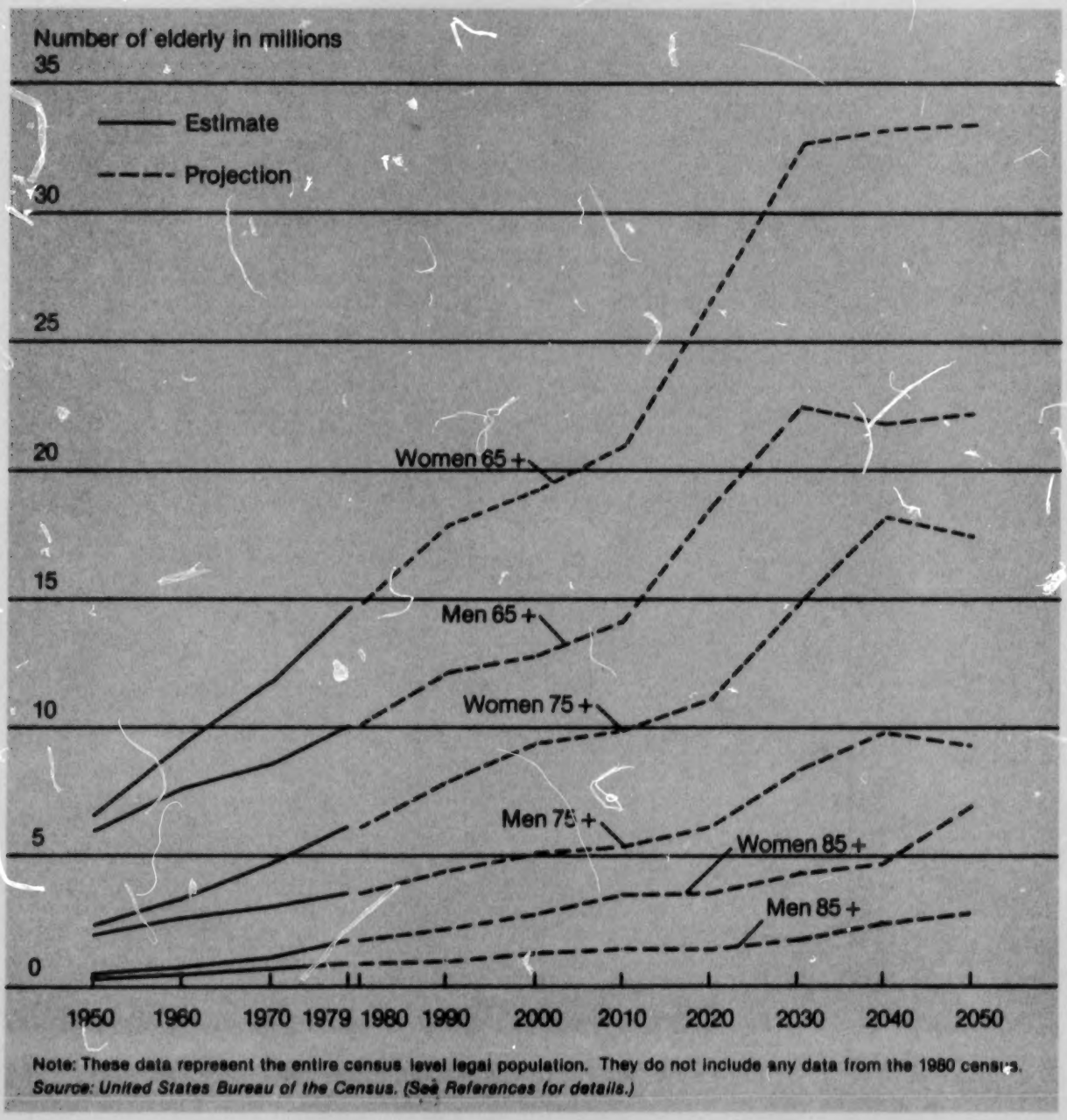
All sex differential studies point to the relative scarcity of elderly men. This is a major reason why so few older women are married (see Charts IV.2 and IV.3) and why so many of them live alone (see Chart IV.1). In 1980 there were about 147 women 65 years old or older for every 100 men in the same age group. At each step up the age ladder the sex differential widens: there are 220 women for every 100 men at 85 and over.

The Census Bureau foresees no relief from the sex differential problem through 2050, but neither does it project any severe worsening. The sex differential will increase slightly to 150 women per 100 men in the year 2000 and 152 women per 100 men 65-plus in 2050.

Actually, elderly women's chances of finding male partners are further reduced by the fact that men usually marry younger women. Elderly widowers often marry much younger women. If, for example, they consistently sought partners 10 years younger, the ratio of potential elderly wives to potential husbands would be still greater: 327 women aged 65 to 74 per 100 men aged 75 to 84; and 628 women aged 75 to 84 for every 100 men aged 85 and over.

Number of elderly by age groups and sex: United States, 1950–2050.

(Chart I.3)



Note: These data represent the entire census level legal population. They do not include any data from the 1980 census.

Source: United States Bureau of the Census. (See References for details.)

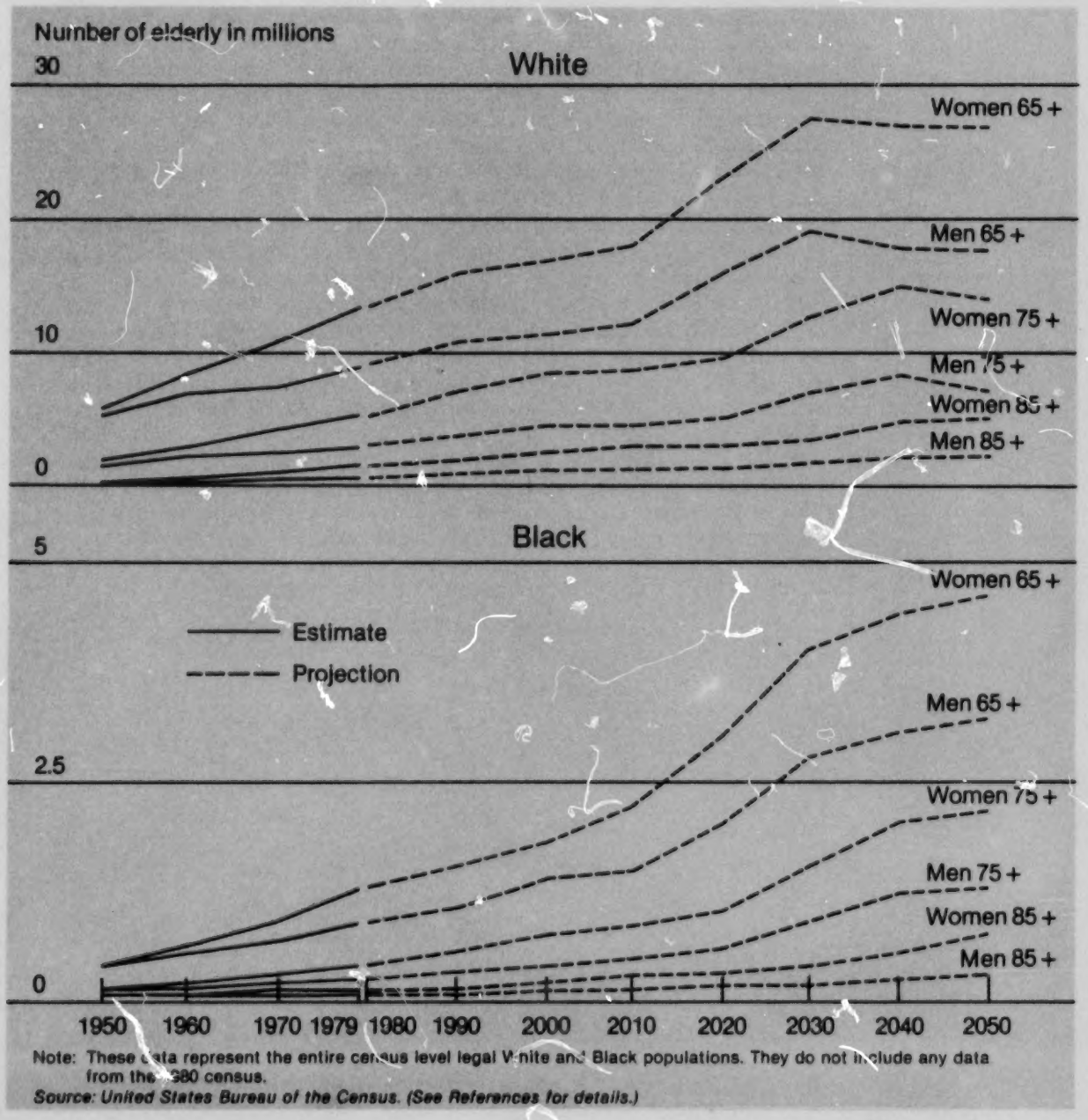
I How does the sex ratio differ between Blacks and Whites?

The relative scarcity of males is less marked in the Black elderly population than among elderly Whites. In 1980 there were 141 Black elderly women 65 and over per 100 Black elderly men, as compared with a White ratio of 148 women to 100 men. At age 75 and over, there are 159 Black women per 100 men compared with 181 per 100 for Whites. The Bureau of the Census projects a similar sex differential for Blacks through the year 2050, but somewhat narrower.

The elderly Black population is increasing faster than elderly Whites generally, in each sex group and in each elderly age subgroup.

Number of White and Black elderly by age groups and sex: United States, 1950–2050.

(Chart I.4)



Note: These data represent the entire census level legal White and Black populations. They do not include any data from the 1980 census.

Source: United States Bureau of the Census. (See References for details.)

In which States do most elderly persons live?

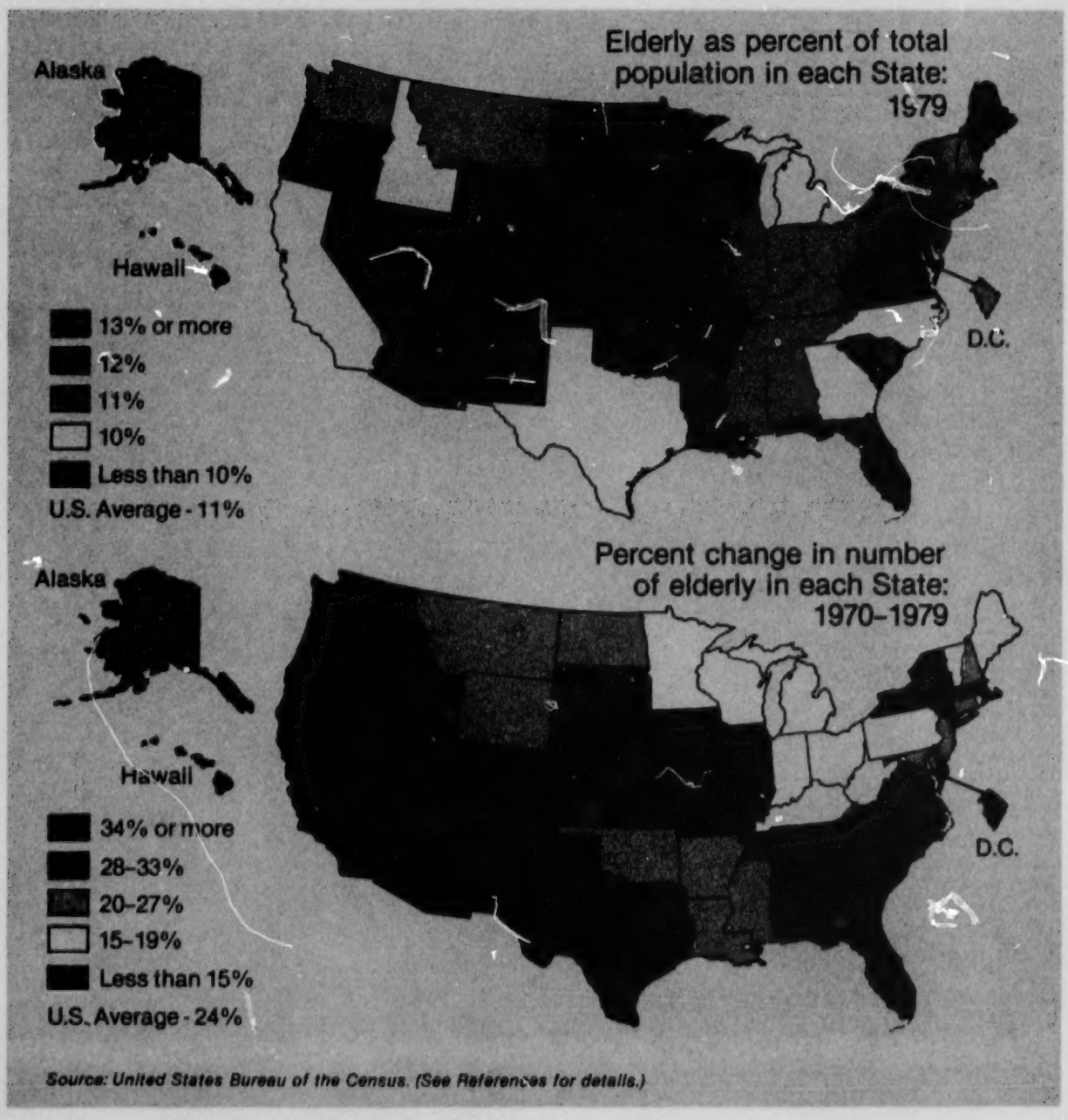
The distribution of the elderly population by State is similar to that of persons of all ages, with a few exceptions. Florida, with 18 percent of its population 65 years old and older, has the highest concentration. States with 13 percent or more elderly population are Pennsylvania, Rhode Island and a contiguous group of Mid-West and Plains States: Arkansas, Missouri, Oklahoma, Iowa, Kansas, Nebraska and South Dakota. Except for Florida, the high concentrations in these States are due more to out-migration of younger persons than to influx of elderly persons.

Other States with relatively high concentrations of elderly persons are Arizona, Oregon and several States in the upper Mid-West and Northeast regions.

States with the highest growth rate of elderly population between 1970 and 1979 are Florida, North and South Carolina, Hawaii, Alaska, Arizona, New Mexico, Nevada, Utah and Idaho. With the exception of Florida, the 10 States with the largest growth rates in their elderly populations are not the same as the 10 States with the highest percentage of elderly persons.

There were seven States in which the 1970–79 growth rate for elderly persons was over twice as high as the growth rate for younger adults. This could indicate a large increase in the potential responsibility for support by younger persons of long term care and other services for the elderly. The States were Hawaii, North Carolina, New York, New Jersey, Pennsylvania, Rhode Island and the District of Columbia.

Distribution of elderly by State: United States, 1970–1979.
(Chart I.5)



Source: United States Bureau of the Census. (See References for details.)

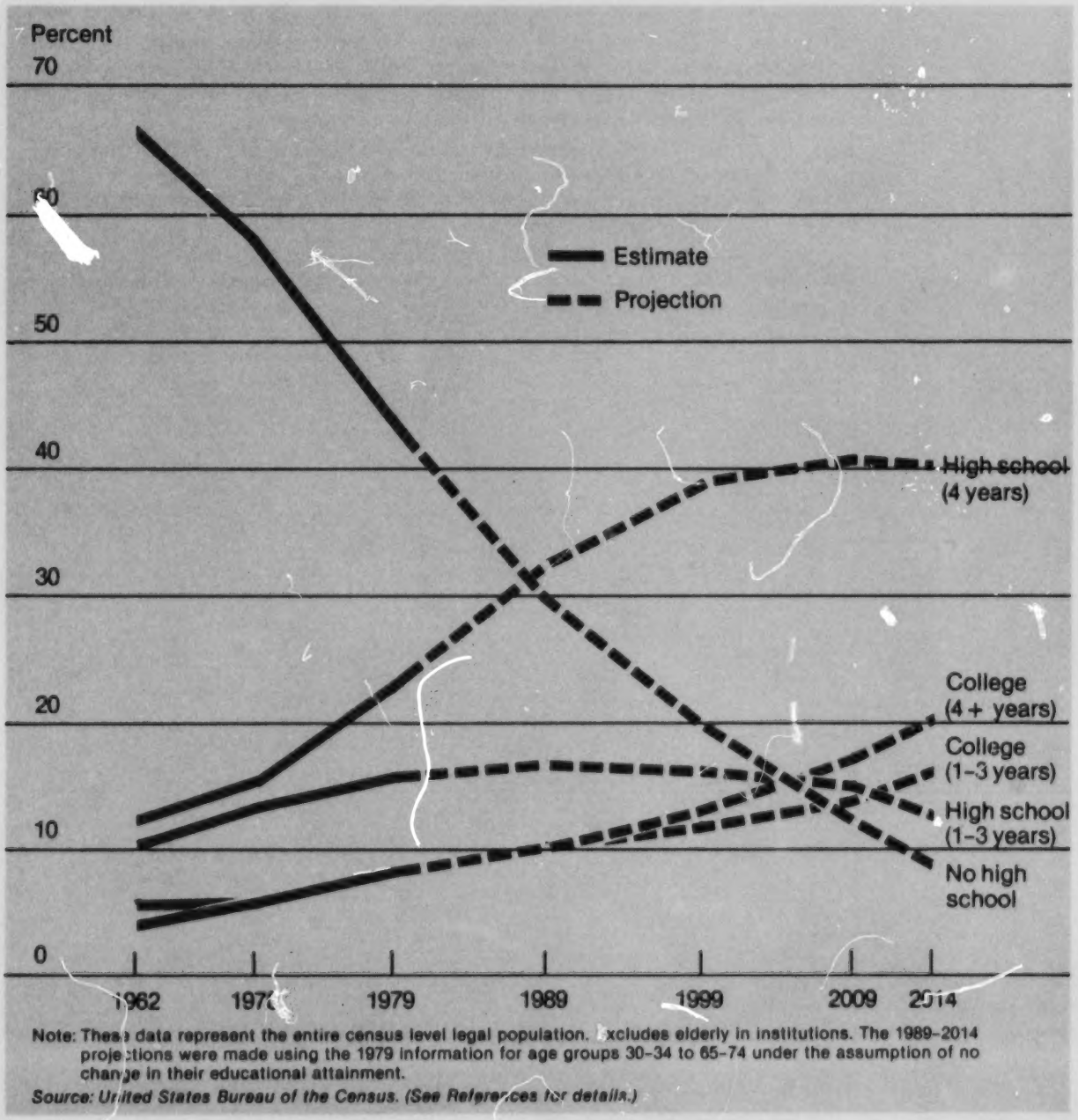
I How much education will tomorrow's elderly have?

Because young people have been getting better educations, the next 30 years will see a dramatic rise in the educational attainment of the elderly. Over 44 percent of those age 65 and over today have never gone to high school. The Census Bureau projects that this will be true of less than 10 percent of the elderly in the early 2000's.

In 30 years the proportion of the elderly population with high school diplomas will rise to 78 percent, compared with 40 percent now. At present, 17 percent of these high school graduates have some college, and in 30 years that proportion will be 37 percent. It is too early to predict the effects of this upgrading, but it suggests that the future elderly may enjoy higher socio-economic status than the present elderly.

Educational attainment of the elderly: United States, 1962–2014.

(Chart I.6)



Note: These data represent the entire census level legal population. Excludes elderly in institutions. The 1989–2014 projections were made using the 1979 information for age groups 30–34 to 65–74 under the assumption of no change in their educational attainment.

Source: United States Bureau of the Census. (See References for details.)

I How are income and education of the elderly related?

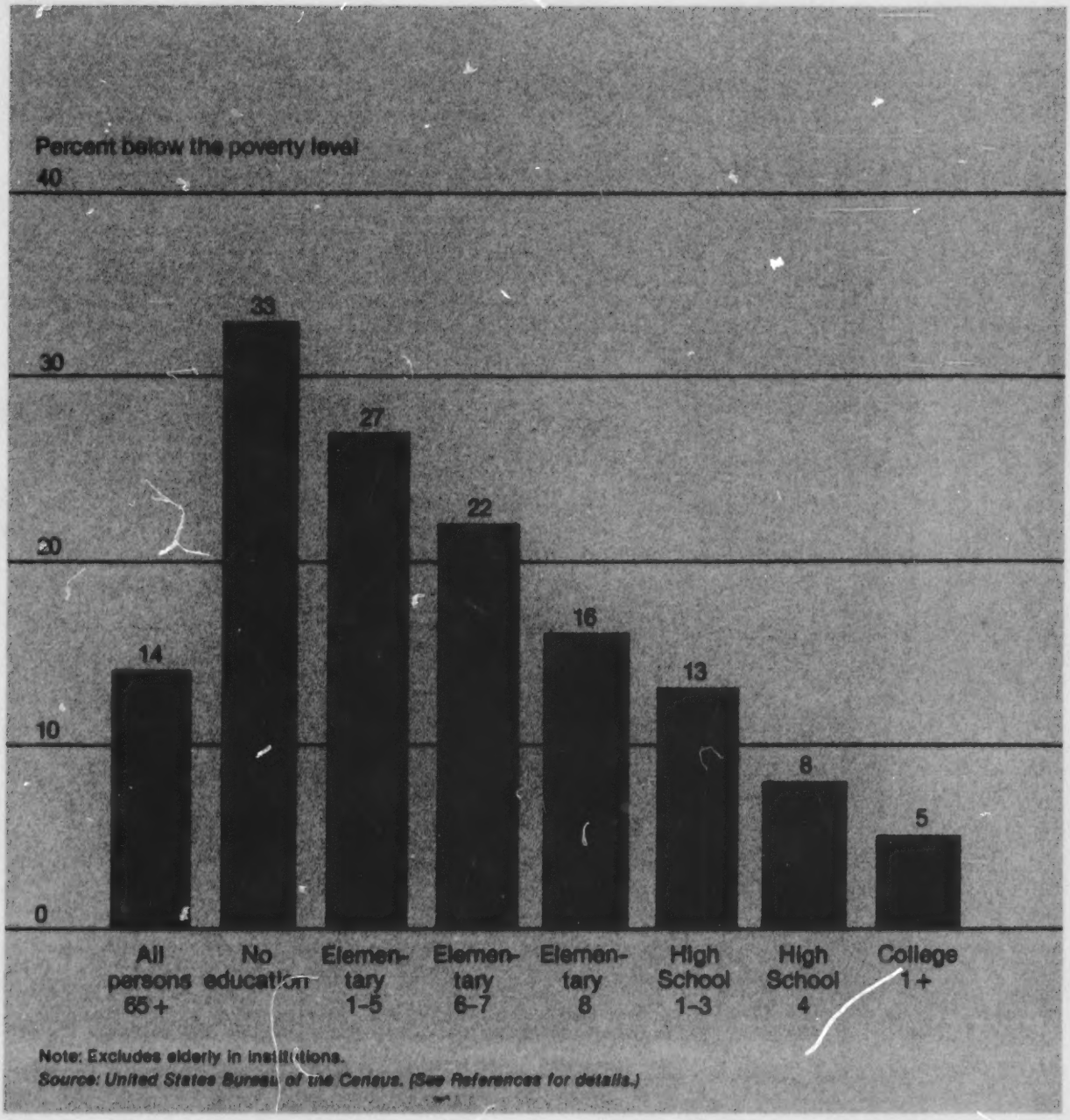
Low educational attainment and low income are closely coupled in the lives of the elderly, as indeed they are for most other population groups. About one-third of all elderly persons with no schooling have incomes below the poverty level. More than a quarter of all elderly who attended school no farther than the fifth grade live in poverty.

Only 8 percent of elderly high school graduates and 5 percent of those who have some college education live below the poverty level. About 14 percent of all older people live below the poverty level, compared to 11 percent of the general population.

Educational attainment will rise sharply during the next 30 years (see Chart I.6) carrying a potential for a decrease in the percent of elderly poor.

Percent of persons 65 and over below the poverty level, according to their educational attainment: United States, 1978.

(Chart I.7)



Note: Excludes elderly in institutions.

Source: United States Bureau of the Census. (See References for details.)

Do elderly households have as much income as others?

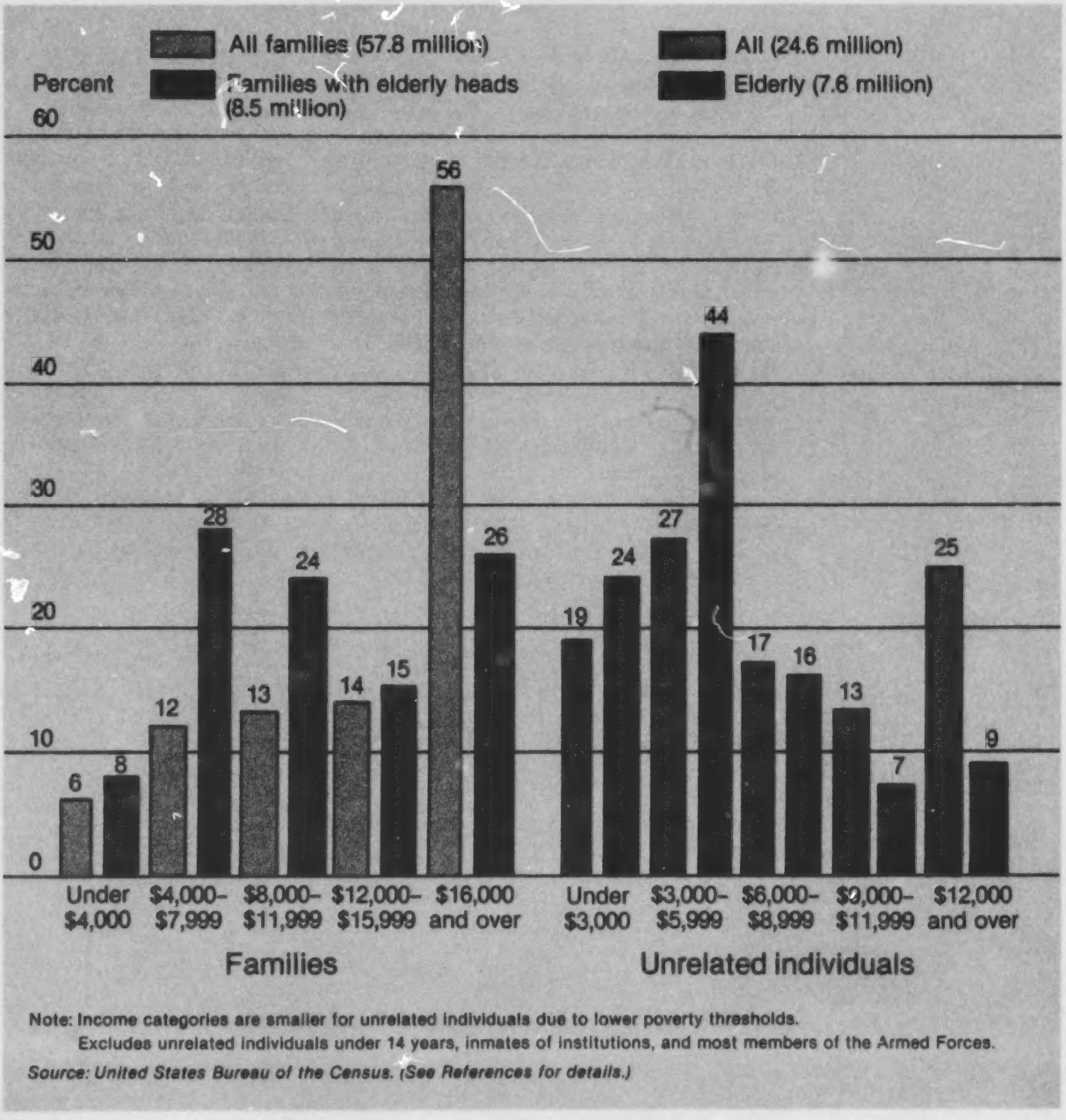
Families headed by elderly persons are apt to have lower income than families headed by persons of all ages. The median income for families with an elderly head is far below the national average: $10,141, compared with $17,640 for all families.

One of every 13 families headed by an elderly person received income under $4,000 in 1978, compared with one of every 17 families in the total population. Only one in four families headed by elderly persons had income of $16,000 or greater in 1978, compared with one in two for all families.

Elderly persons living alone or with non-relatives are even more concentrated at the low end of the income scale. Sixty-eight percent of these elderly unrelated individuals received incomes of less than $6,000 in 1978 compared to 46 percent for all unrelated individuals. The median incomes for these groups were $4,303 for elderly and $6,705 for all persons in 1978.

Percent distribution of families and unrelated individuals by income levels: United States, 1978.

(Chart I.8)



Note: Income categories are smaller for unrelated individuals due to lower poverty thresholds.
Excludes unrelated individuals under 14 years, inmates of institutions, and most members of the Armed Forces.

Source: United States Bureau of the Census. (See References for details.)

I How many elderly live below the poverty level?

Significant gains have been made in reducing poverty among elderly Americans in the last two decades. But 3 million elderly were still living below the poverty level in 1978, when an elderly person was counted as poor if income did not exceed $3,116.

Expressed in percentages of the population, 14 percent of the elderly live below the poverty level now, compared with 11 percent of the general population. This contrasts with 35 percent of the elderly living in poverty in 1959.

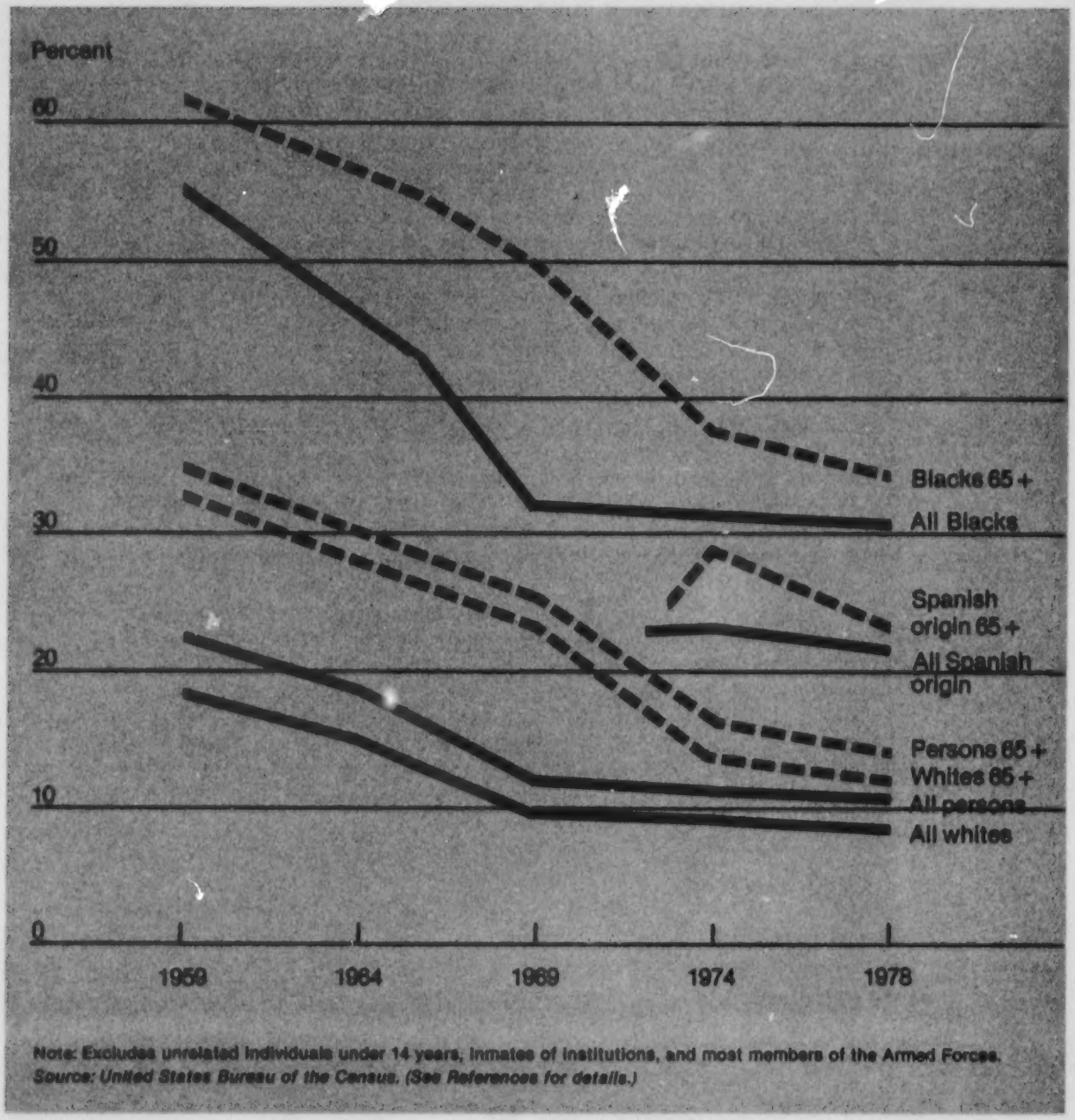
Between 1959 and 1978, the poverty rate for Black elderly declined from 63 percent to 34 percent. In the same period White elderly experienced declines in poverty from 33 percent to 12 percent. Thus poverty in 1978 was three times more prevalent among Blacks. The available data show a relatively constant pattern of poverty for elderly and non-elderly persons of Spanish origin in the 1972 to 1978 period.

The decline in the number of elderly poor over the 1970's was due largely to increases in Social Security benefit levels. One reason that the number of elderly poor has not changed in the last few years is that Social Security benefits and poverty thresholds are now both tied to the Consumer Price Index.

Recent data for 1979 not on Chart I.9 show that poverty increased among the elderly. For all elderly the rate rose to 15 percent; for White elderly, 13 percent; for Black elderly, 36 percent; and for persons of Spanish origin, 27 percent.

Percent of elderly below the poverty level by race and Spanish origin: United States, 1959–1978.

(Chart I.9)



Note: Excludes unrelated individuals under 14 years, inmates of institutions, and most members of the Armed Forces.
Source: United States Bureau of the Census. (See References for details.)

I How many elderly live slightly above the poverty level?

Five million elderly Americans, about 25 percent of the elderly population, were living below 125 percent of the poverty line in 1978. The 125-percent-of-poverty reading is presented because many users of current official poverty statistics feel that these rates tend to understate the extent of social and economic deprivation.

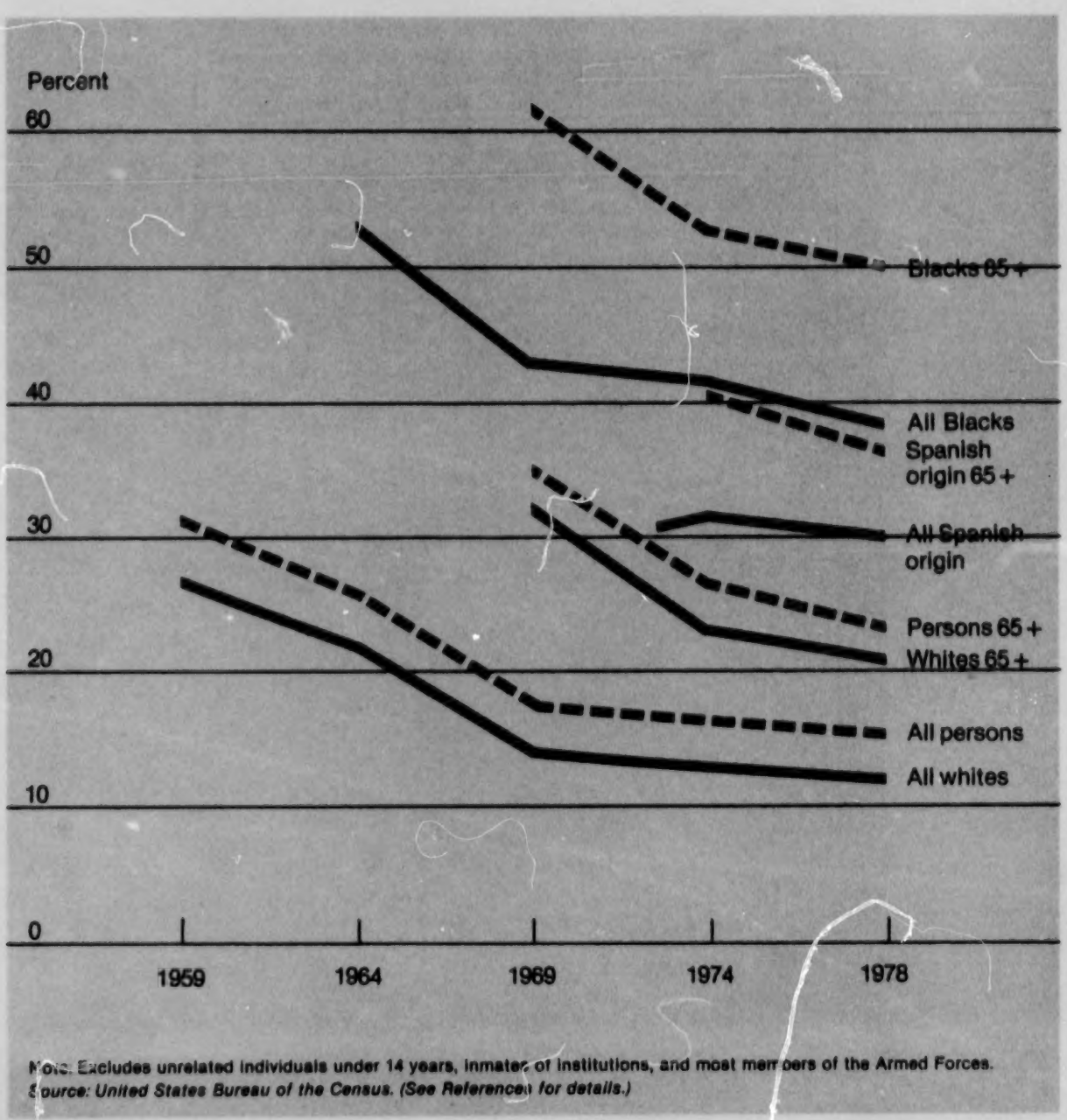
Although data for elderly persons do not exist for the entire 1959–1978 period, it is clear that significant reductions in the 125 percent rate have taken place. Thirty-five percent of elderly persons were below the near-poverty level in 1969 compared with 23 percent in 1978. The decline is similar to that of elderly persons below the poverty line (see Chart I.9).

White elderly persons saw their 125 percent-of-poverty rate fall from 33 percent to 21 percent, while the rate for elderly Blacks fell from 61 to 50 percent. Elderly Blacks thus were about two and a half times as likely as elderly Whites to have incomes below 125 percent of the poverty line. Elderly persons of Spanish origin experienced modest declines in their near-poverty level over a limited time frame.

One difference should be noted in the generally similar rates of decline between the poverty and near-poverty measures. In 1978, the poverty rate for elderly Blacks was only slightly higher than for all Blacks, but the 125 percent-of-poverty rate for elderly Blacks was substantially higher than the comparable rate for all Blacks. Thus, it appears that there are significant numbers of marginally poor elderly Blacks.

Percent of elderly below 125 percent of the poverty level by race and Spanish origin: United States, 1959–1978.

(Chart I.10)



Note: Excludes unrelated individuals under 14 years, inmates of institutions, and most members of the Armed Forces.
Source: United States Bureau of the Census. (See References for details.)

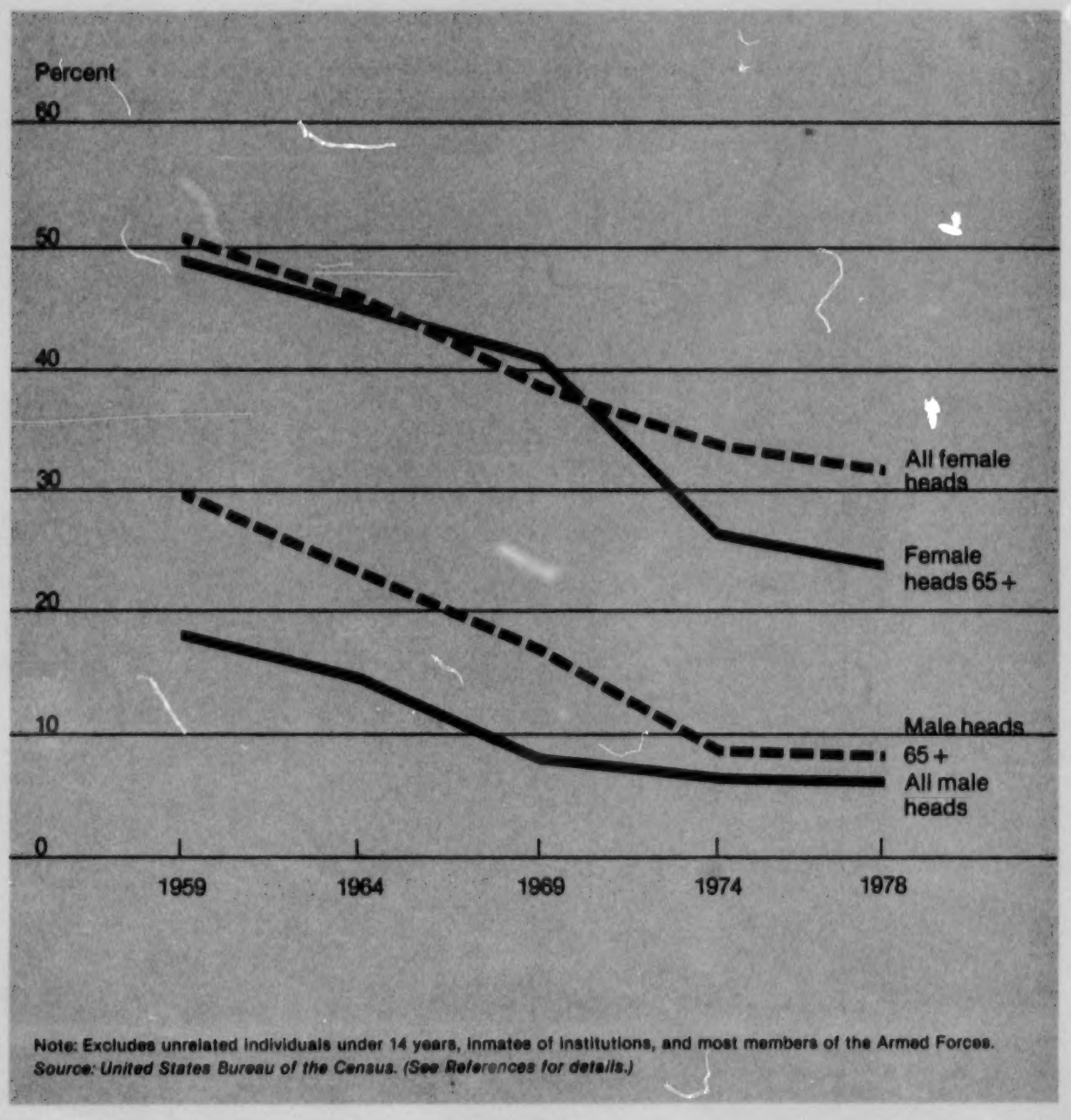
I Do elderly families headed by females have higher poverty rates?

Chances of living below the poverty level are almost three times as great for elderly persons in female-headed families as in male-headed families. Nine percent of the elderly in male-headed families and 24 percent of those in female-headed families are poor.

In this respect, elderly persons have experienced the same trends as the general population, where the incidence of poverty is substantially higher for female-headed families than for male-headed families. Over time, the poverty rate for male-headed families has fallen twice as fast as for those headed by females. In 1978, persons living in female-headed families were five times more likely to be poor.

Percent of elderly below the poverty level by sex of family head: United States, 1969–1978.

(Chart I.11)



Note: Excludes unrelated individuals under 14 years, inmates of institutions, and most members of the Armed Forces.
Source: United States Bureau of the Census. (See References for details.)

I Does sex of family head have the same poverty tendency for Blacks?

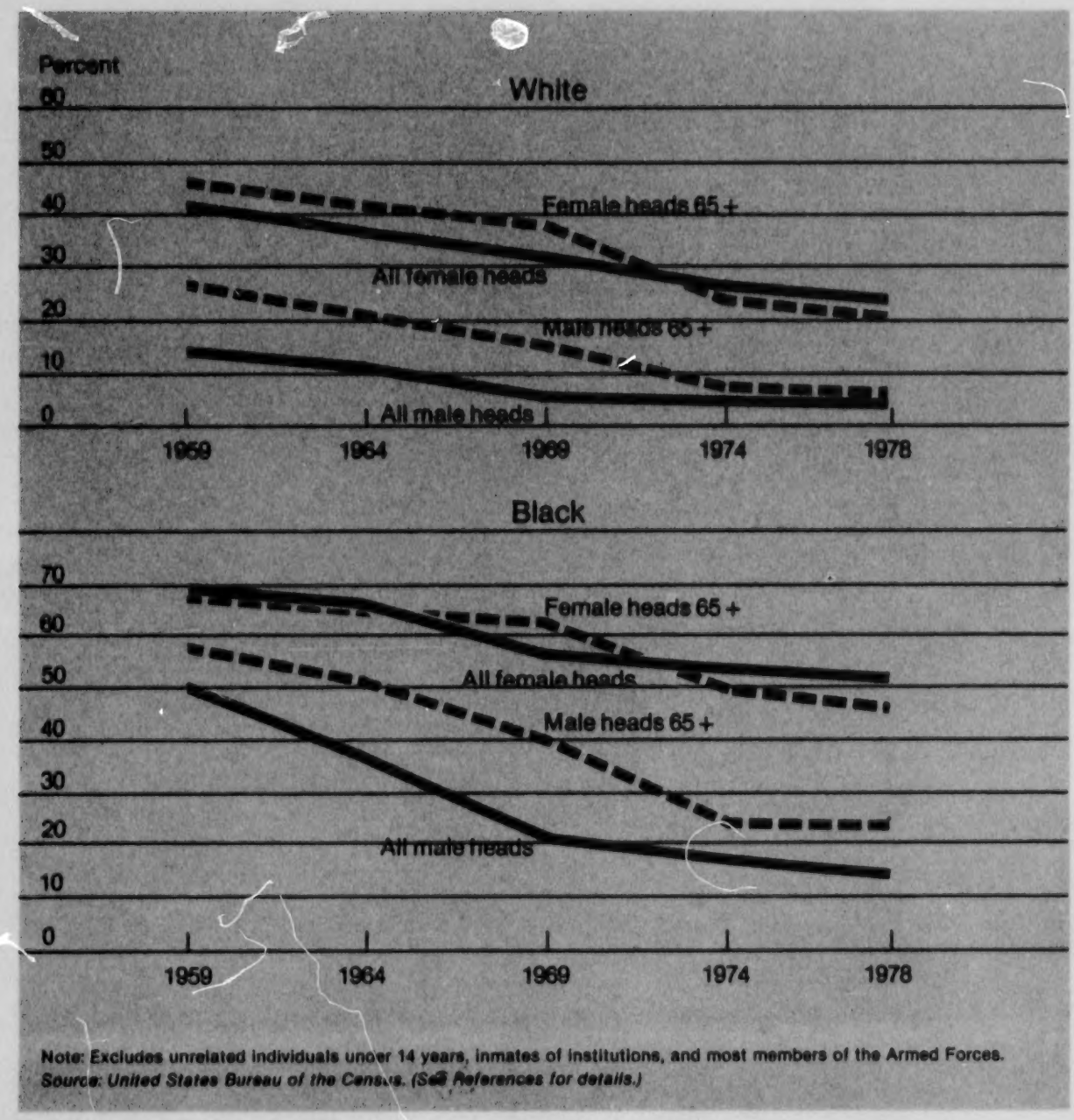
Regardless of race, poverty rates are lowest for persons of all ages in families headed by males. The largest poverty rates are experienced by persons of all ages living in families headed by females.

Although the order remains the same for Black families and White families, poverty rates for the families headed by Blacks are always substantially higher than for those headed by Whites.

33

Percent of elderly below the poverty level by race and sex of family head: United States, 1959–1978.

(Chart I.12)



Note: Excludes unrelated individuals under 14 years, inmates of institutions, and most members of the Armed Forces.
Source: United States Bureau of the Census. (See References for details.)

II Health Status

II Health Status

Introduction

With increasing age, a growing number of elderly persons experience limitations in normal activities due to a chronic condition. But not until age 75 does a majority report such limitations.

The mental health of the elderly is an important factor in determining whether family members provide care when the person cannot function independently. However, information on the mental health status of the elderly is extremely sparse. Available information indicates that from 15 to 25 percent of the elderly have significant symptoms of mental illness.

The capacity to carry out tasks of daily living is one measure of the need for long term care. Need for assistance increases with age. Yet the vast majority of very old, non-institutionalized persons remain independent in basic daily activities such as dressing, bathing, toileting and eating.

Issues raised by these data include the following: What are the best health status indicators of the need for long term care? How can both mental and physical factors be taken into consideration in determining need? What will be the impact if "optimistic" projections of life expectancy are realized? To what extent will 80 year olds in 2000 be as healthy as 80 year olds of today? Will reductions in mortality lead to more or less need for assistance?

II To what degree are the elderly limited in their activities?

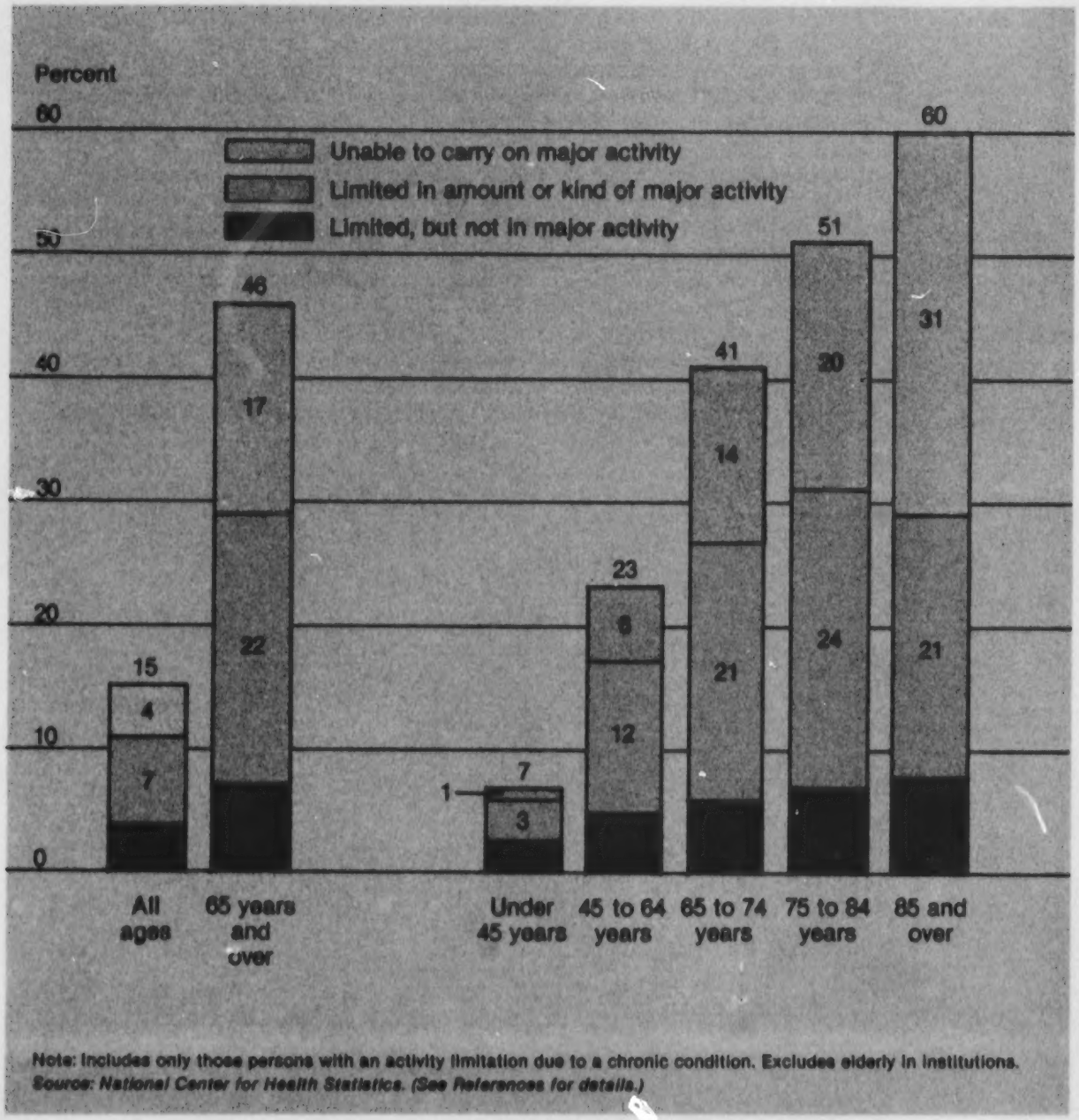
Prevalence of chronic diseases and conditions increases with age. Most elderly persons have at least one chronic condition and many elderly persons have more than one. But the severity or seriousness of any particular chronic disease may vary greatly from individual to individual. For example, one person with arthritis may be restricted to his or her home year round while another may suffer only an occasional flare-up. For this reason, measurement of the number of persons with various conditions really does not tell much about the ability of the elderly population to cope with the tasks of daily living without assistance.

It is more useful to measure health status or physical capacity in terms of the degree of limitation that persons experience in carrying out their normal activities. But even this does not provide a very precise means for determining need of assistance.

A significantly higher proportion of persons 65 and over than of those under 65 years of age experience some limitation of activity due to a chronic condition, although not until age 75 does a majority report such limitations.

Percent of elderly with limitation of activity due to chronic condition by age groups and type of limitation: United States, 1978.

(Chart II.1)



Note: Includes only those persons with an activity limitation due to a chronic condition. Excludes elderly in institutions.
Source: National Center for Health Statistics. (See References for details.)

II How many elderly need assistance in daily living?

The capacity to carry out activities and tasks of daily living such as dressing, bathing, toileting and eating is one of the measures of need for long term care assistance. Functional status, as this is called, is generally a more direct measure of need for assistance than is either disease diagnosis or level of activity limitation.

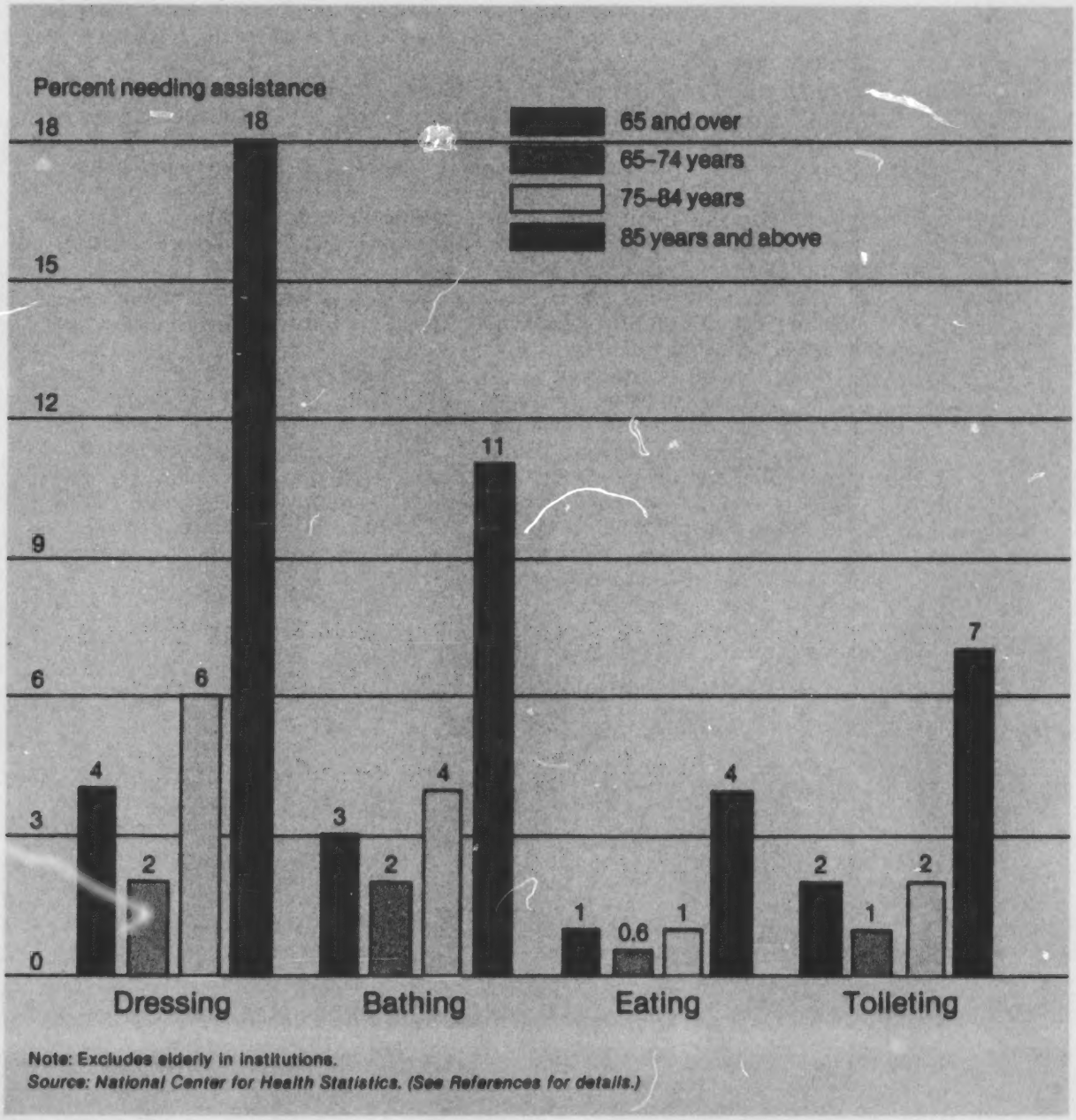
Several methods are used to measure functional status. Some of the methods record the level of mental and social impairment as well as physical incapacity. Degree of mobility also is frequently used to indicate capacity to perform such activities of daily living as household cleaning and shopping.

As would be expected, fewer people have difficulty with activities such as eating and toileting than with activities such as dressing and bathing, which require greater or more complex body movement.

Need for assistance is significantly greater among the older elderly population than among younger elderly. Even so, the vast majority of the very old non-institutionalized population remains independent in all of these activities.

Percent of elderly needing assistance in four activities of daily living by age groups: United States, 1978.

(Chart II.2)



Note: Excludes elderly in institutions.

Source: National Center for Health Statistics. (See References for details.)

II What is the mental health status of the elderly?

There are no firm figures on prevalence of mental health problems among the elderly. Here are some general estimates taken from a variety of sources.

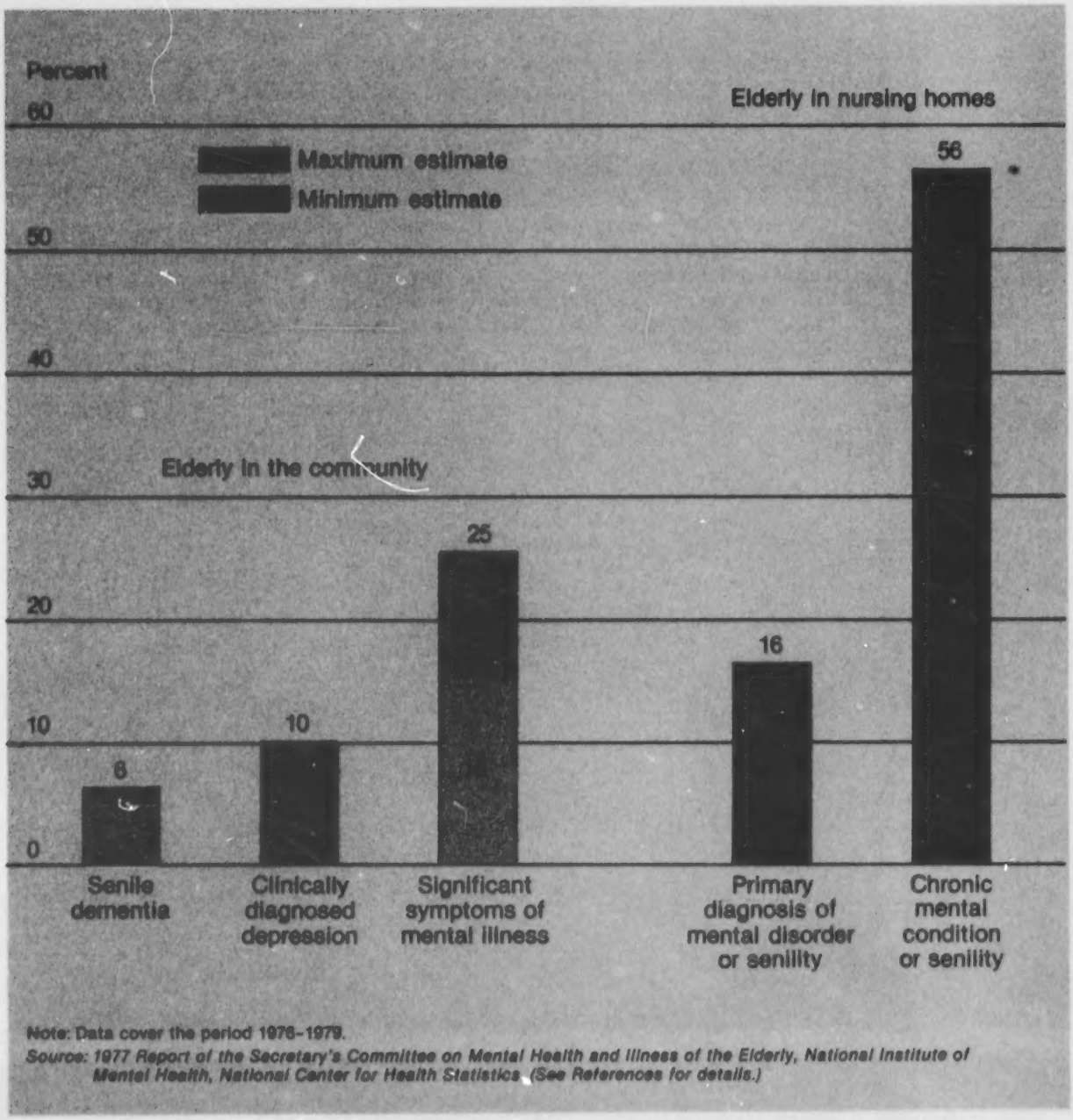
Of the elderly living in the community, from 15 to 25 percent may have significant symptoms of mental illness. From 5 to 6 percent may experience "senile dementia". About 10 percent experience clinically diagnosed depression. Among nursing home residents 65 and over, 16 percent have a primary diagnosis of mental disorder or "senility". An additional statistic, not shown on this chart, is that persons 65 and over commit 16 percent of known suicides although they constitute 11 percent of the population.

It is a popular misconception that senility is widespread among the elderly and is an untreatable condition. In a recent publication[1] on the subject, the National Institute on Aging notes that "senility" is the word commonly used to describe a large number of conditions with an equally large number of causes, many of which respond to prompt treatment. Mental decline in old age might be called "dementia", "organic brain disorder", "chronic brain syndrome", "arteriosclerosis", "cerebral atrophy", or "pseudodementia". Some of the problems which are generally referred to under the medical description of senile dementia can be treated and cured, while others, at this time, can only be treated without hope of restoring lost brain function. Thus a complete, careful investigation of the source of the symptoms is necessary.

[1] *Senility, Myth or Madness?*, Age Page, National Institute on Aging, U.S. Department of Health and Human Services, October 1980.

Selected mental health measures for the elderly by place of residence: United States.

(Chart II.3)



Note: Data cover the period 1976–1979.

Source: 1977 Report of the Secretary's Committee on Mental Health and Illness of the Elderly, National Institute of Mental Health, National Center for Health Statistics. (See References for details.)

II How many years of life remain for those age 65 and over?

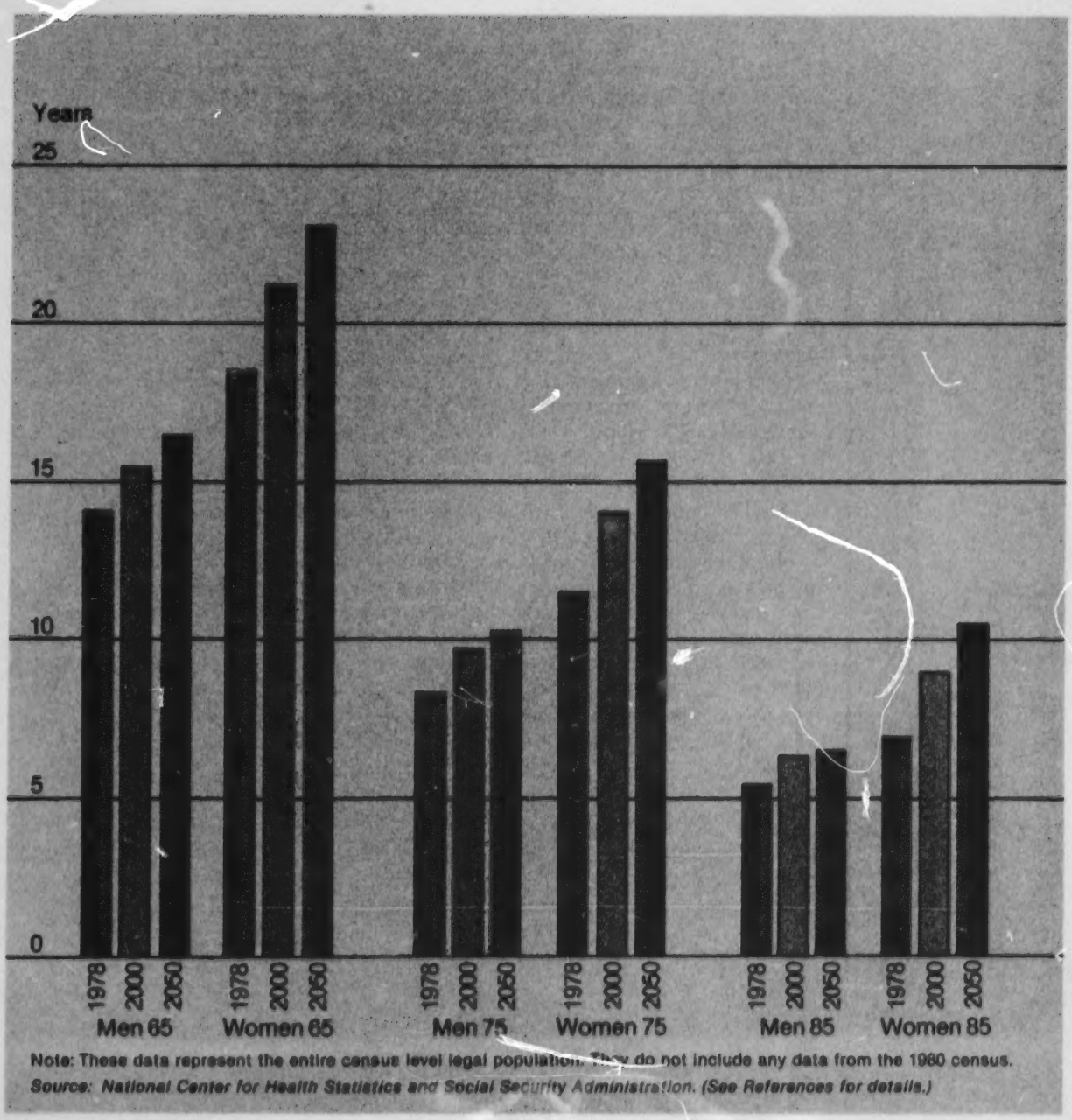
Elderly women of whatever age can expect to live longer than men of the same age. In 1978, women aged 65 could expect to live an average of 18 additional years. Such men could expect to live 14 more years.

By 2050, women aged 65 are projected to average 23 additional years of life. Men aged 65 will only live 17 additional years then. By 2050, elderly men are not expected to live as long as women already did in 1978. That is also true for men aged 75 or 85 in the year 2050.

This chart is based on National Center for Health Statistics data and Social Security Administration mortality projections which are slightly more recent than those used by the Census Bureau in preparing the latest available population projections in Charts I.1 through I.4. If the projections in this chart prove more accurate, there will be even more elderly people alive in the next century than indicated in the charts of Section I.

The average number of years of life remaining for the elderly by age groups and sex: United States, 1978, 2000, and 2050.

(Chart II.4)



Note: These data represent the entire census level legal population. They do not include any data from the 1980 census.

Source: National Center for Health Statistics and Social Security Administration. (See References for details.)

II How will the elderly's health status change over the years?

Although there is no direct evidence that the health status of today's elderly is better than that of recent past generations, the small but significant increase in longevity beyond age 75 suggests that improvement has occurred. It should be noted that the increase in average length of life that has occurred in this century derives primarily from overcoming childhood and childbearing mortality. In generations past, adults who reached late maturity lived almost as long as people do today.

What about the future? Will the 80 year old in the year 2000 or at some point beyond have the health status of the 80 year old person today? If one assumes the ultimate average life-span to be approximately 85 years, as in Charts II.5A and B, most of the increase in length of life over what existed at the turn of the century has already been realized. Not all agree that such a biological limit on the human life-span exists, however.

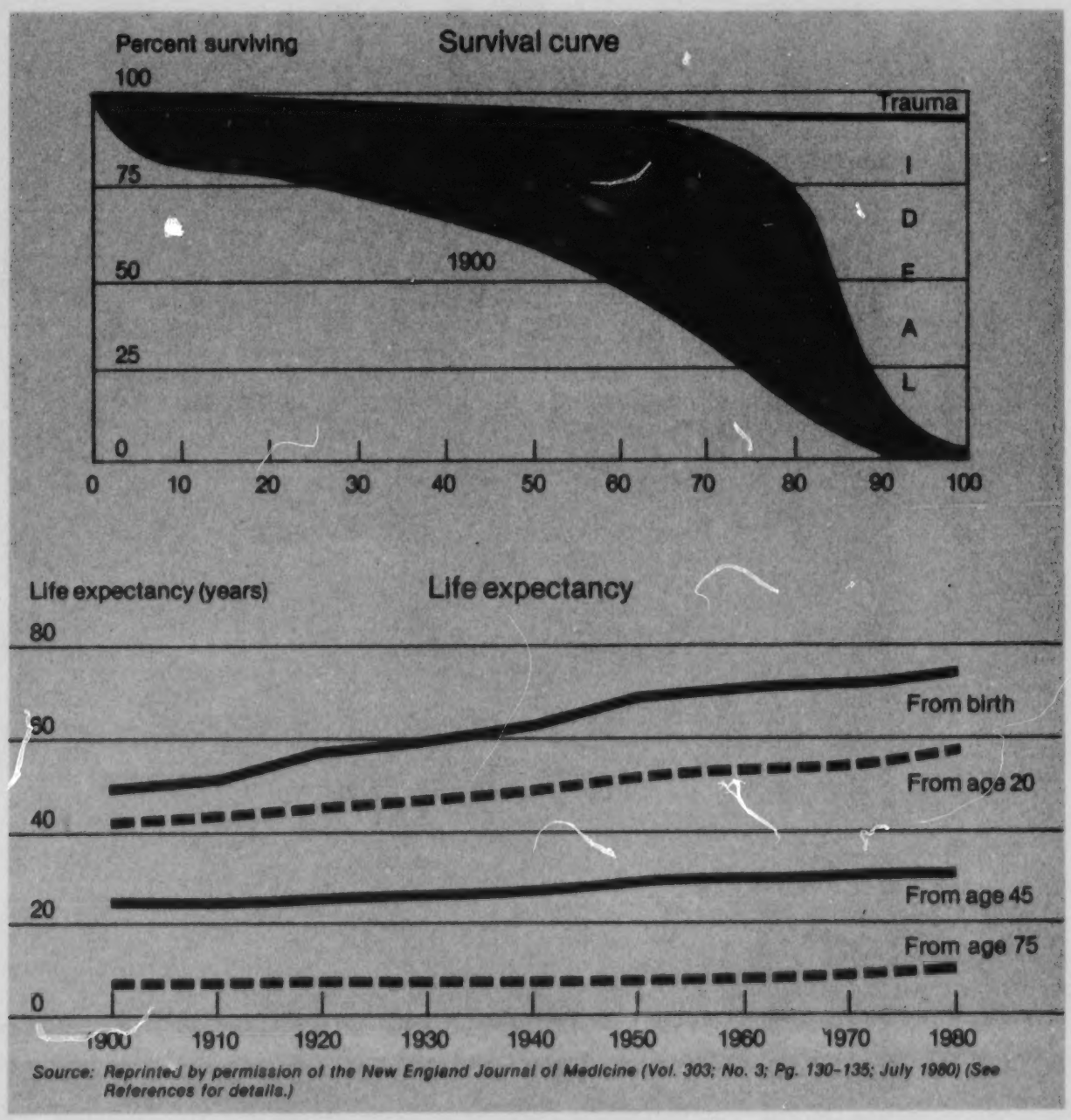
If such a life-span limit does exist *and the major dependency-inducing diseases were eliminated or delayed,* the period of dependency prior to "natural" death would be shortened. This outcome would mean less need for long term care in the future than is typically projected.

On the other hand, if no biological limit exists, or if it substantially exceeds 85 years, the period of dependency created by any remaining chronic diseases (or new diseases that might take their place) would not be shortened as much as *delayed* in onset until an older age than is the case today. This outcome would mean greater need for long term care in the future. Further, a decrease in mortality rates does not necessarily mean that the survivors are "well" and the need for long term care would decrease. Survivors may be disabled to the point that they will require more assistance in daily activities for longer periods of time.

In any event, any significant change in the pattern of need for long term care that might be observable at some future points is unlikely to appear abruptly or in the foreseeable future.

The increasingly rectangular survival curve, and life expectancy trends: United States.

(Chart II.5)



Source: Reprinted by permission of the New England Journal of Medicine (Vol. 303; No. 3; Pg. 130-135; July 1980) (See References for details.)

III Health Services

Introduction

The elderly have more health problems and use more health services than the general population. They enter hospitals twice as often and stay twice as long as the general population. They make about four visits to the doctor for every three visits made by the general population. Their use of nursing homes has increased rapidly since the mid 1960's. In spite of their mental health problems, they use mental health services at only about half the rate of the general population.

Although the elderly comprise 11 percent of the population, 29 percent of all health care expenditures in 1978 were spent for their care.

Out-of-pocket payments for health care are a major expense for the elderly. They pay about 29 percent of their health care costs out-of-pocket including 50 percent of all nursing home expenses.

Some of the issues raised by the elderly's use of health services include: To what extent is the medical care model applied to those who need long term care? To what extent are acute hospital care and nursing home care used inappropriately when social care is not available in the community? To what extent are social care services provided through the medical care system? To what extent are the mentally ill transferred out of the mental health system and into nursing homes? To what extent must the elderly use their own funds to pay for long term care services? To what extent does the availability of public funds dictate the type of care received?

III How are the elderly using short-stay hospitals?

Elderly persons have increased their use of short-stay hospitals substantially since 1965, the year the Medicare program was enacted. (It became operational in 1966.)

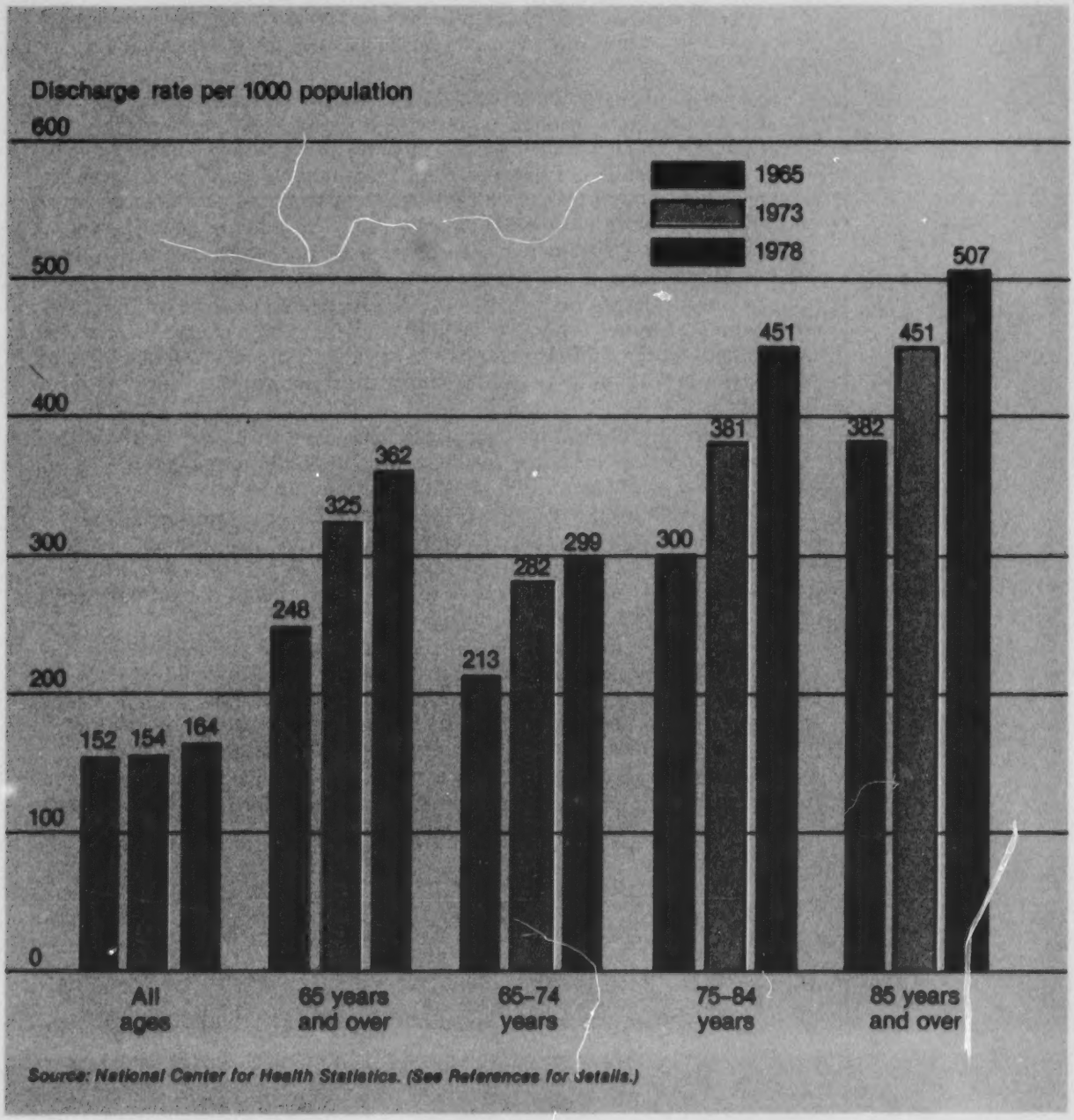
A 46 percent increase occurred in the number of discharges per 1,000 patients 65 years old and older between 1965 and 1978. For patients of all ages, an 8 percent increase occurred over the same period.

Because health problems tend to increase with age, the hospital discharge rates for the elderly also tend to increase. For example, elderly persons 85 and over have a hospital discharge rate 70 percent above that of elderly persons between ages 65 and 74.

Of course the discharge rate is only one indicator of hospital usage. Other basic measures would be the percent of hospital discharges over age 65 (25 percent in 1978) and the percent of hospital operations performed on the elderly (20 percent in 1978). For duration of stay, see Chart III.5.

Use of short-stay hospitals by the elderly by age groups: United States, 1965, 1973, and 1978.

(Chart III.1)



III How are the elderly using nursing homes?

Of the 1.3 million nursing home residents in 1977, 86 percent were 65 years old and over. They constitute about 5 percent of the nation's elderly.

The typical nursing home resident is a widow about 81 years old. Compared with non-institutionalized elderly, nursing home residents are more likely to be without spouse. About 74 percent are widowed, divorced or never married, while only 41 percent of non-institutionalized elderly are living without spouse. These figures suggest that the absence of spouse and family to provide informal supports may be a factor precipitating admission to a nursing home. (See Section IV on Informal Support for further discussion.)

In general, nursing home residents are restricted in their ability to move about. About 70 percent require assistance in walking or are chairfast or bedfast. In addition to physical health problems, about 56 percent of elderly nursing home residents suffer from mental disorders or "senility".

Use of nursing homes, like hospitals, increases with age. In 1977, there were about 13 nursing home residents per 1,000 persons aged 65–74 and about 216 residents per 1,000 persons 85 years and over.

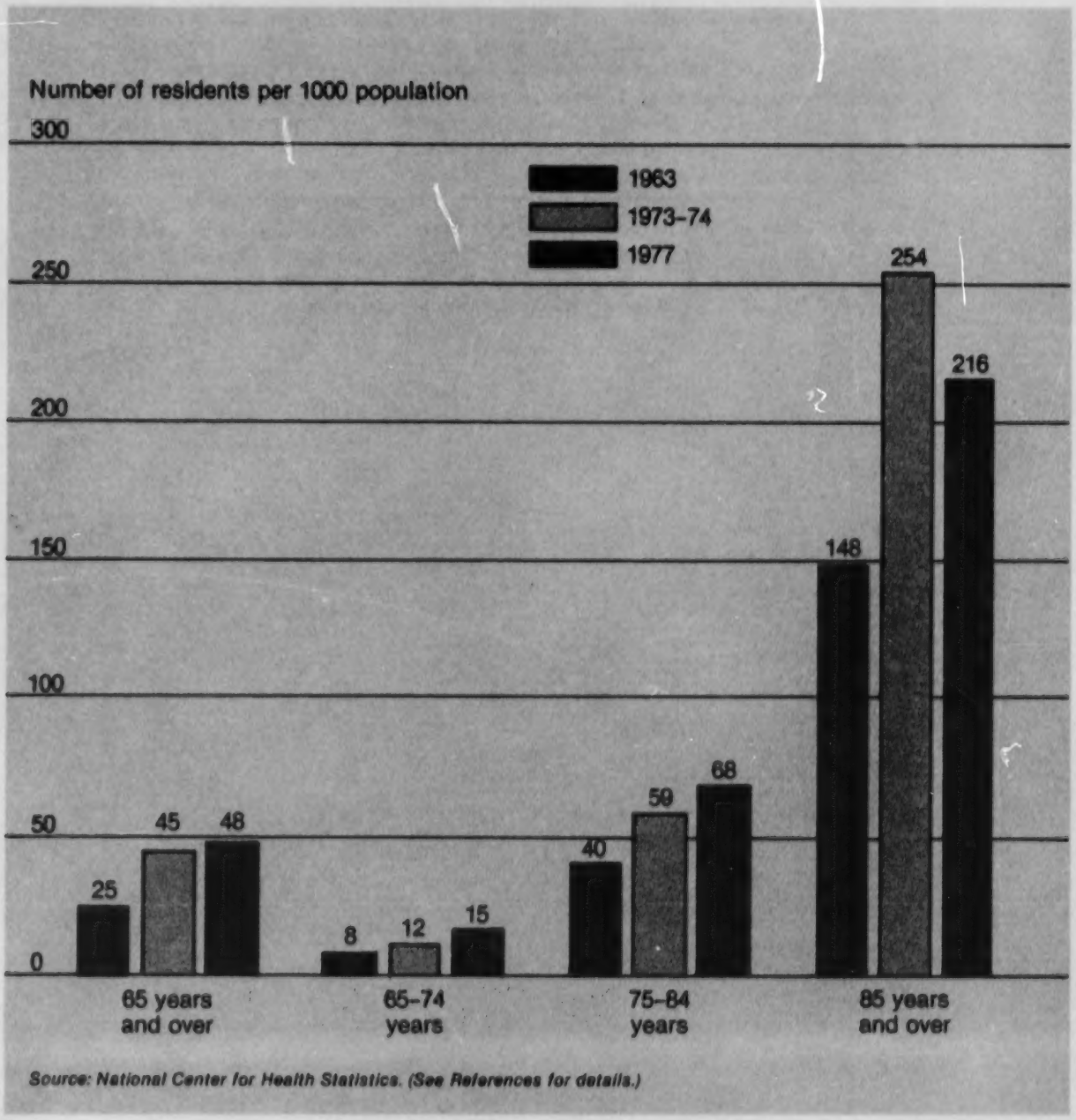
The Medicaid program is the principal purchaser of nursing home services. Forty-eight percent of the residents were reported as having Medicaid as the primary source of payment in 1977. Medicare, which was designed to cover acute care costs for the elderly, was the primary source of payment for only 2 percent of the residents.

The rate of nursing home use increased rapidly in the mid-1960's and early 1970's after implementation of Medicare and Medicaid in 1966 and the liberalization of eligibility requirements in 1972. Prior to Medicaid, the more limited use of public funds for nursing home care prevented many potential users of nursing homes from obtaining such care.

Increased use of nursing homes by the elderly is likely in the near future because of the growing proportion of the elderly in the population.

Use of nursing homes by the elderly by age groups: United States, 1963, 1973–74, and 1977.

(Chart III. 2)



Source: National Center for Health Statistics. (See References for details.)

III How often do the elderly visit the doctor?

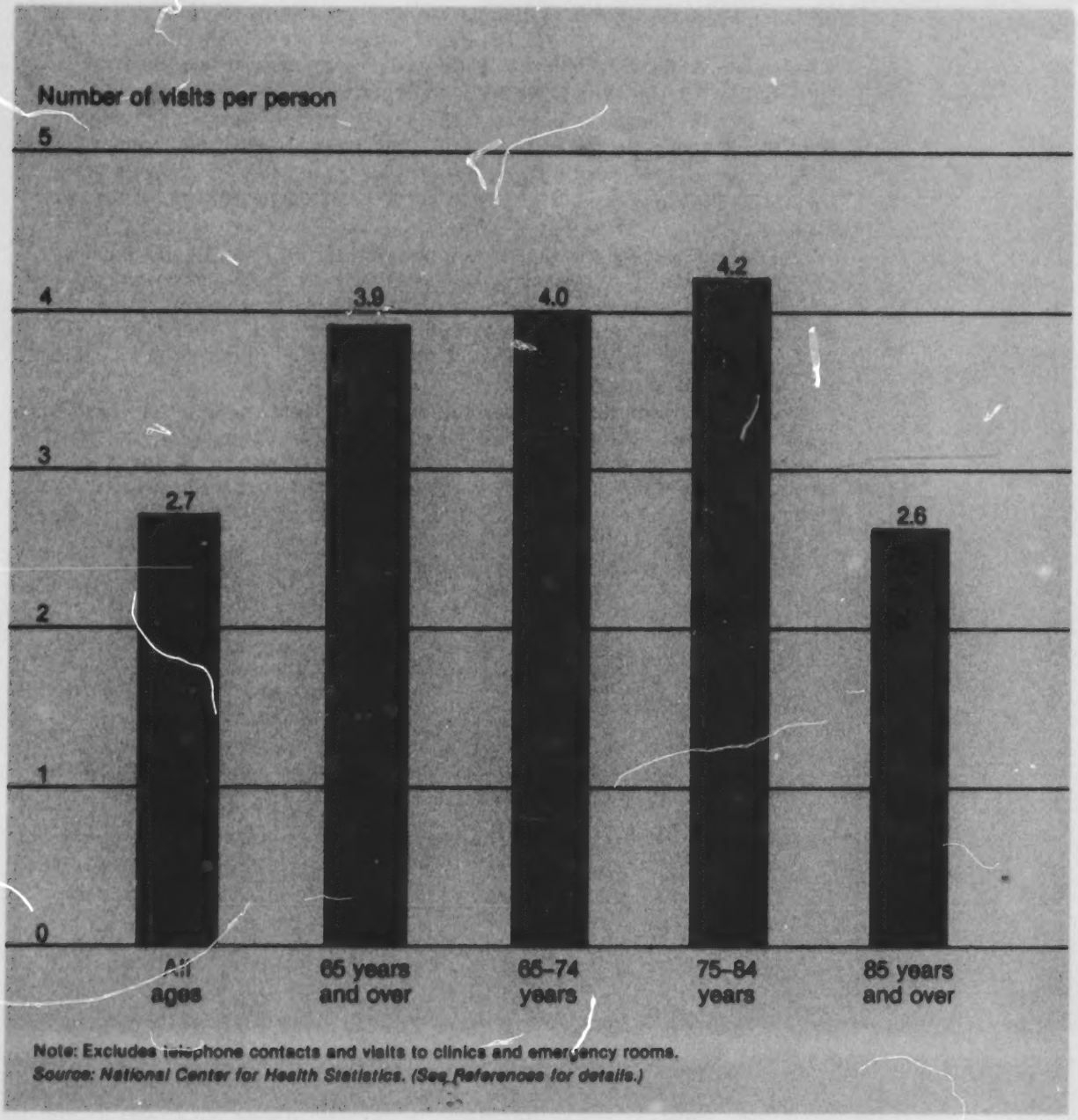
Between ages 65 and 84, the elderly make substantially more visits to physicians' offices than do persons of all ages—about 4 visits a year, compared with about 3 per year for the general population.

Compared with younger patients, the elderly have more return visits for the same problems, visit internists more frequently, have electrocardiograms and blood pressure checks more often, and have a much greater proportion of visits for diseases of the circulatory system. They are twice as likely as younger patients to have a chronic condition.

However, the oldest of the old make substantially fewer visits to physicians than younger patients do. This may be due to a tendency to use hospitals and nursing homes over ambulatory care (as shown in Charts III.1 and III.2) for those in the oldest age groups.

Visits to physicians by the elderly by age groups: United States, 1978.

(Chart III.3)



Note: Excludes telephone contacts and visits to clinics and emergency rooms.
Source: National Center for Health Statistics. (See References for details.)

III How are the elderly using mental health services?

The elderly use mental health services at about half the rate of the general population—7 versus 16 admissions per 1000. This difference in admissions is most notable for State and county mental hospitals and community mental health centers and other outpatient services.

Among the elderly, admission rates were generally higher for women, for the younger elderly aged 65 to 74, and for those with no spouse.

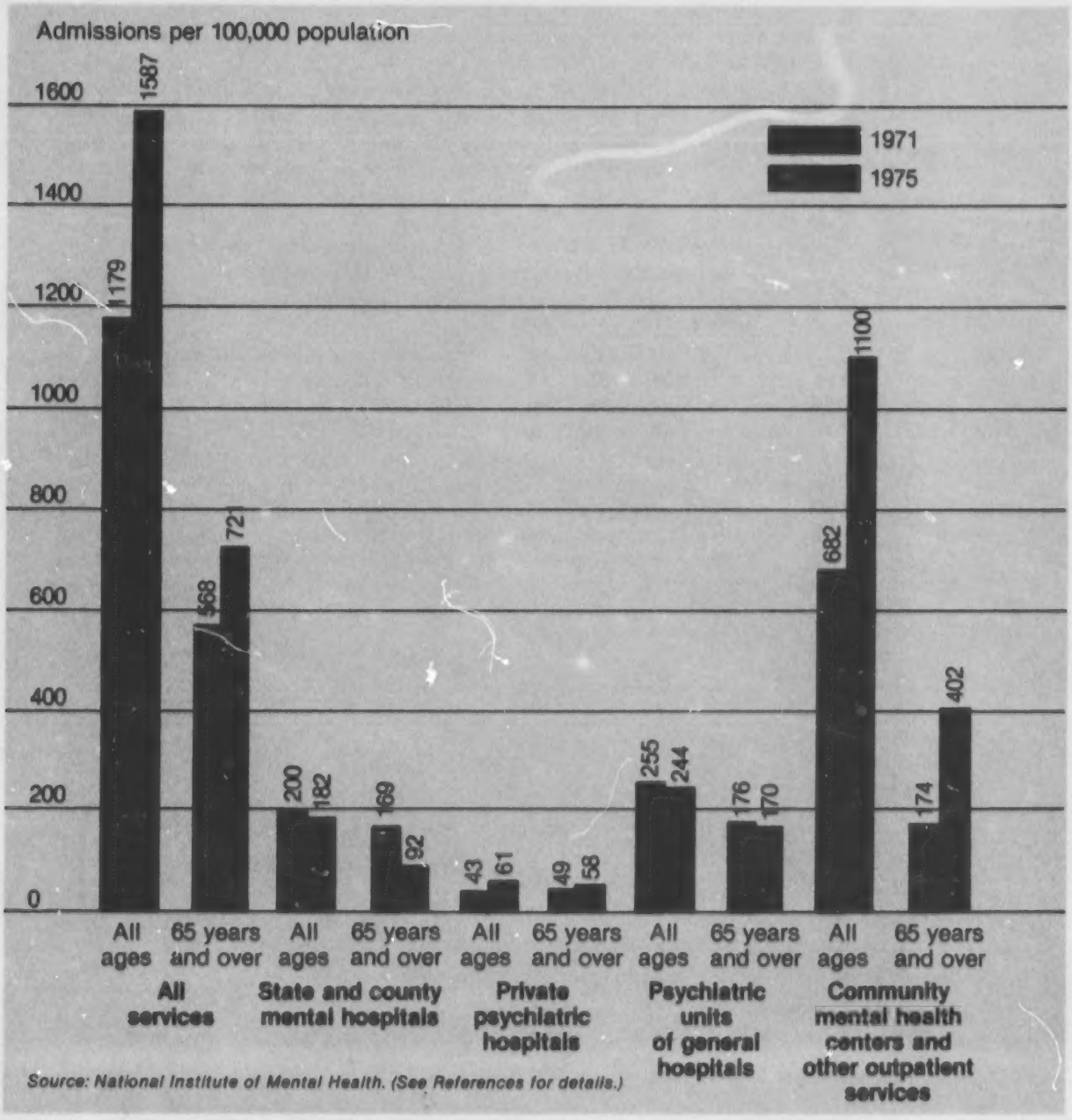
Although their rate of usage remained relatively low, the elderly increased their use of mental health services by 27 percent between 1971 and 1975.

Since the 1960's, there has been a shift in the locus of mental health care for the elderly. Admissions by the elderly to State and county mental hospitals have declined while admissions to community mental health centers and outpatient services have increased. Nevertheless, the elderly comprise only 4 to 5 percent of the caseload of community centers and outpatient services.

Even more dramatic than the shift from inpatient to outpatient mental health services is the transfer out of the mental health system and into nursing homes. From 1969 to 1973, the number of nursing home residents with mental health problems doubled to reach 194,000 persons.

Use of mental health services by the elderly: United States, 1971 and 1975.

(Chart III.4)



Source: National Institute of Mental Health. (See References for details.)

III How long do the elderly stay in health institutions?

As seen in Charts II.1–II.3 on health status and III.1–III.4 on use of health services, the elderly have more health problems and use more health services than the general population.

One measure to determine whether the services the elderly receive are of the same intensity as the general population is to examine the duration of stay in health institutions. Compared with the general population, elderly discharges have double the median days of stay in short-stay hospitals and in State and county mental hospitals. For stays in nursing homes and private psychiatric hospitals, however, there is no appreciable difference between usage by elderly and the general population.

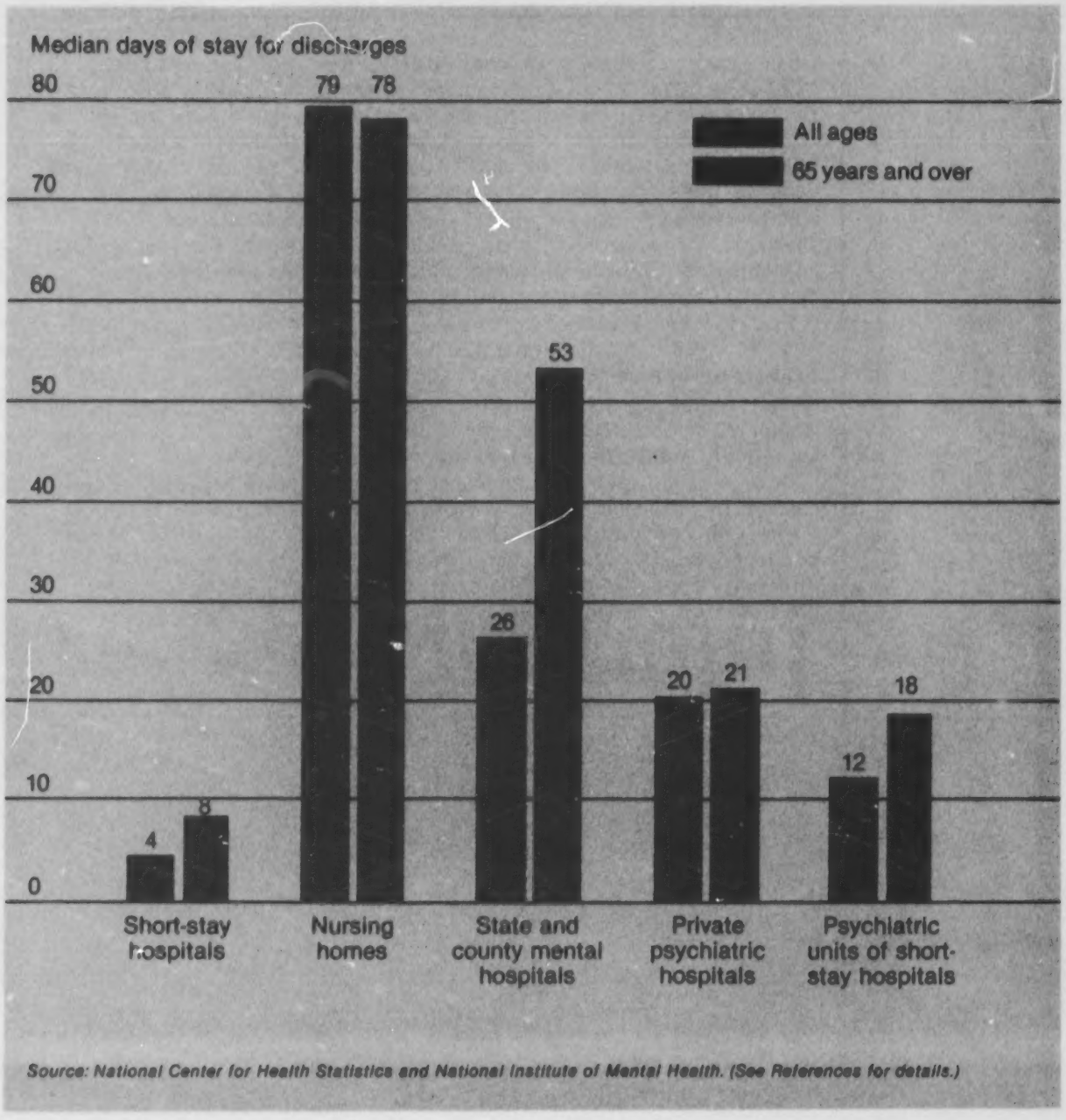
Duration of stay differs by type of health care institution. The longest is 78 days for elderly discharged from nursing homes; the shortest is 8 days in short-stay hospitals.

About 74 percent of elderly nursing home patients are discharged alive; the most frequent referral is to a general hospital. Less than one percent are referred to mental hospitals although 12 percent have a mental health problem as their primary diagnosis.

For elderly discharged from State and county mental hospitals, the most usual referral is to outpatient psychiatric services. For discharges from private psychiatric hospitals and psychiatric units of general hospitals the most usual referral is to a private psychiatrist. Nursing homes, which usually provide few mental health services, rank as the second most frequent place of referral for discharges from all types of psychiatric institutions.

Median days of stay for the elderly discharged from health institutions: United States, 1975.

(Chart III.5)



Source: National Center for Health Statistics and National Institute of Mental Health. (See References for details.)

III

Although the elderly comprise 11 percent of the population, 29 percent of the health care expenditures in 1978 were for their care. This is not surprising given the greater volume and intensity of services they receive. In 1978, $2026 was spent per capita for the elderly's health care. In comparison, $764 was spent for younger adults and $286 for youths. Hospital care was by far the largest portion of the elderly's health bill. Nursing home care was the next highest and the services of physicians, dentists, and other professions was third.

Public funds paid for 63 percent of the elderly's health care in 1978. This contrasts sharply with the situation which existed in 1965, before enactment of Medicare and Medicaid. Public funds then paid for only 30 percent of the elderly's care.

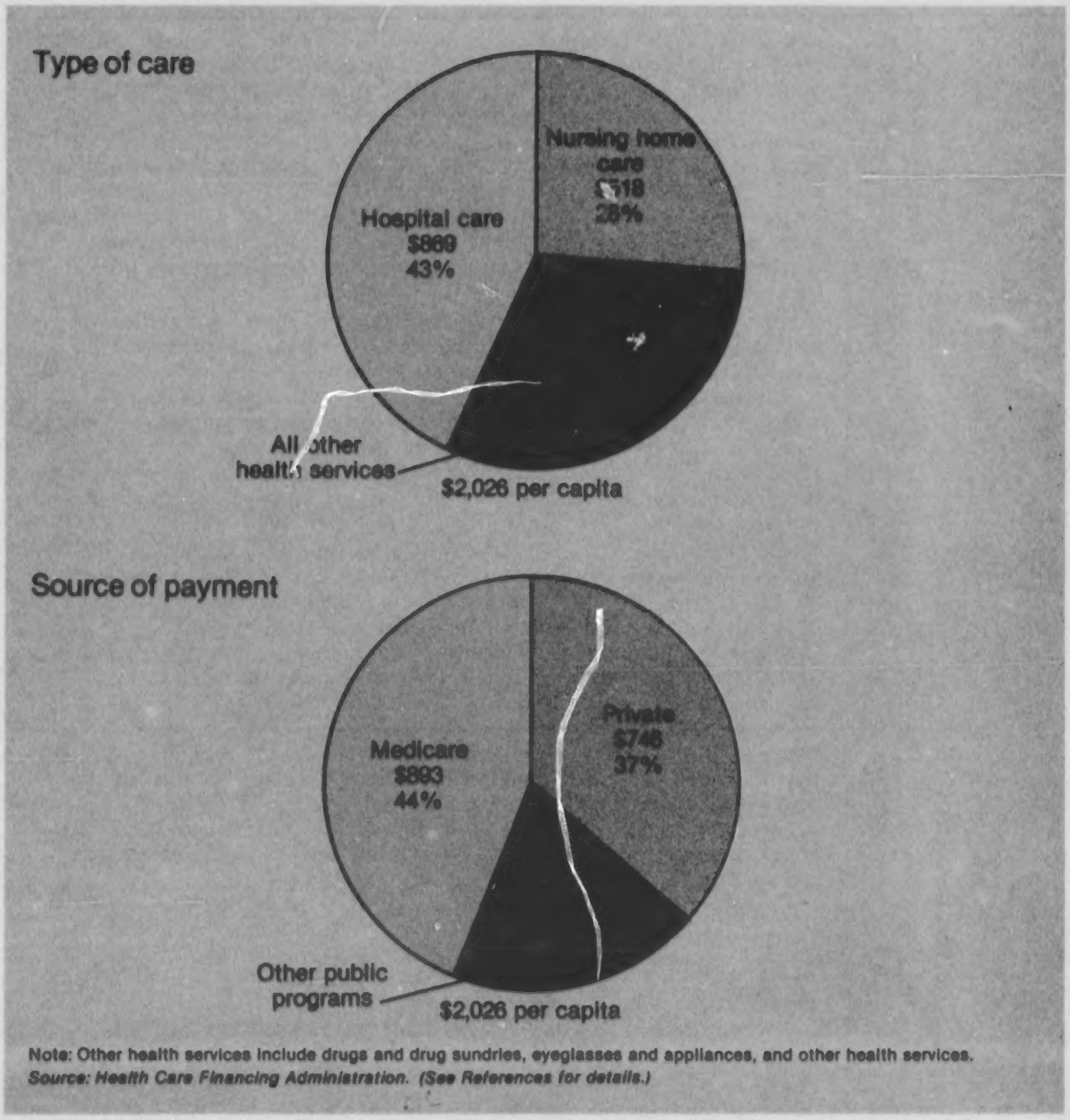
In 1978, the largest part of the elderly's health care was paid by Medicare, 44 percent. Medicaid paid for 13 percent and other public programs paid about 6 percent.

Use of public funds differed by type of care. For hospital care, public funds, mostly Medicare, paid for 88 percent of the bill. For nursing home care, public funds, mostly Medicaid, paid for 46 percent.

Out-of-pocket payments for health care are a major expense for the elderly. In 1977 they paid 29 percent of their health care costs out-of-pocket. This amounted to $528 of their $1821 per capita costs. The proportions paid out-of-pocket vary considerably by type of care. For hospital care, the out-of-pocket payment was 5 percent of the costs, for physician services 26 percent, and for nursing home care 50 percent.

Per capita health care expenditures for the elderly by type of care and source of payment: United States, 1978.

(Chart III.6)



Note: Other health services include drugs and drug sundries, eyeglasses and appliances, and other health services.
Source: Health Care Financing Administration. (See References for details.)

III How much will the nation spend on health care in 1990?

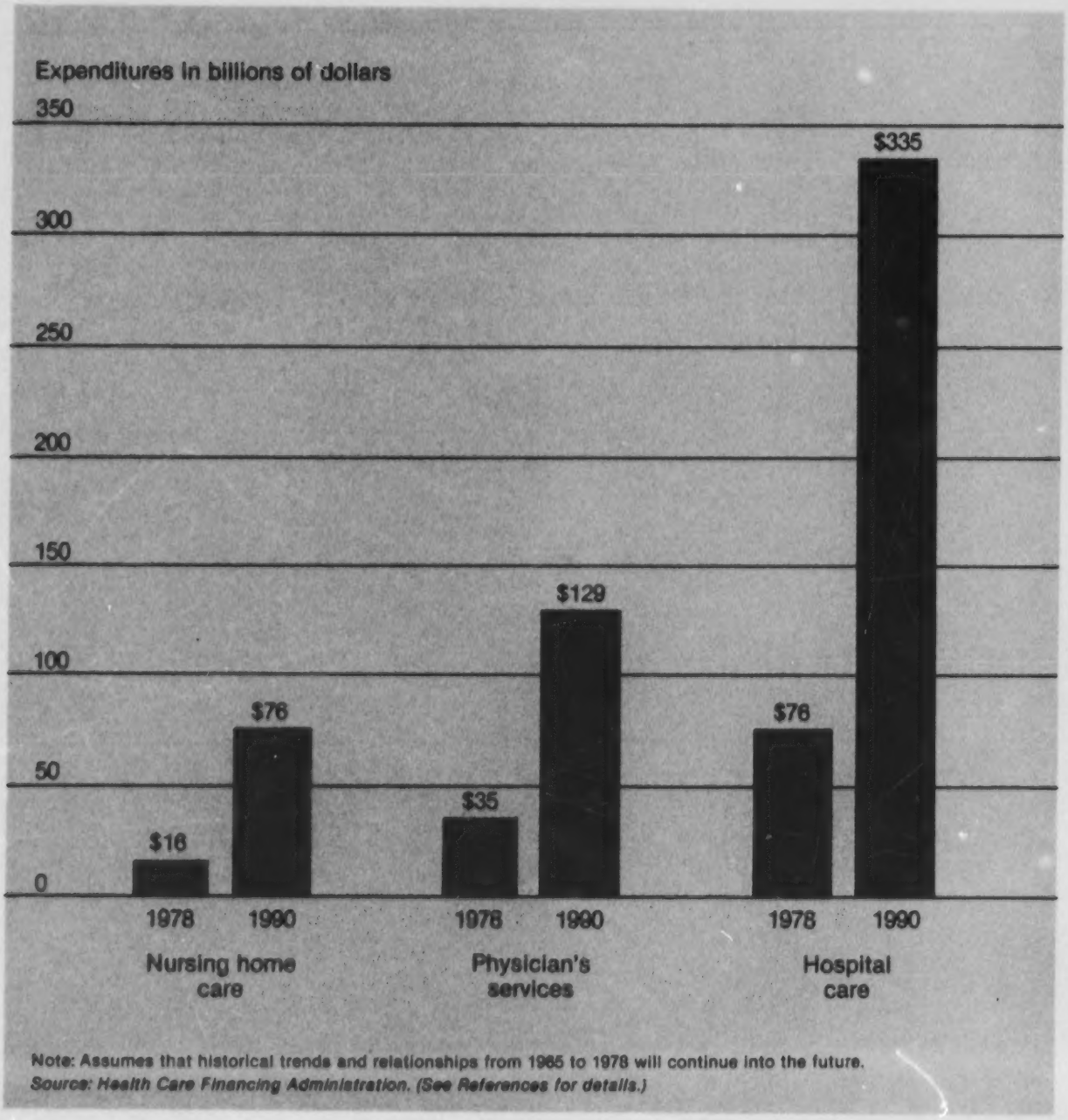
Since 1965, the Nation's health care expenditures have approximately doubled every six years. This rapid growth is projected to continue into the near future. By 1990, total health care expenditures will increase nearly four times from $192 to $758 billion. The basic assumption in making these projections is that trends in the medical care sector of the economy from 1965 to 1978 will continue into the future. In particular, it is assumed that the use of medical care will increase according to the 1965–1978 trends and no major publicly-financed medical programs will be implemented. It is also assumed that no major breakthroughs in treatment of illness will occur to change patterns of disability and death. See the text to Chart II.5 for a discussion of the impact on the need for long term care if this last assumption does not hold in the future.

Hospital care, physician services and nursing home care are the three largest segments of the nation's health care expenditures. By 1990, expenditures for hospital care and for physicians' services are projected to increase about four times. Nursing home costs, the fastest growing segment of health care expenditures, are projected to increase by nearly five times the 1978 amount. The major factors cited for this rapid increase include increases in life expectancy, increases in public expenditures, and increases in prices that nursing homes pay for providing care, especially in the area of wages.

One hypothesis concerning the reason for increases in the nation's health expenditures is a shift in the provider of care. Care once provided for "free" by household members is now provided by health professionals. This shift is especially noteworthy in the long term care area. A major factor that contributes to this shift is the increase since 1965 of women in the labor force—from 39 to 50 percent. Thus, fewer women are available in the household during the day to provide care. Another factor is that as the average household size decreases, there are fewer household members of either sex available to provide care. Hence, care that had been provided "free" by household members is increasingly provided for a fee by a health professional. Section IV on informal supports, especially Charts IV.4, IV.5, and IV.8, gives more information about this shift and its impact on the population in need of long term care.

Projected expenditures for health services by type of service: United States, 1978 and 1990.

(Chart III.7)



Note: Assumes that historical trends and relationships from 1965 to 1978 will continue into the future.

Source: Health Care Financing Administration. (See References for details.)

III How will use of health services by the elderly change?

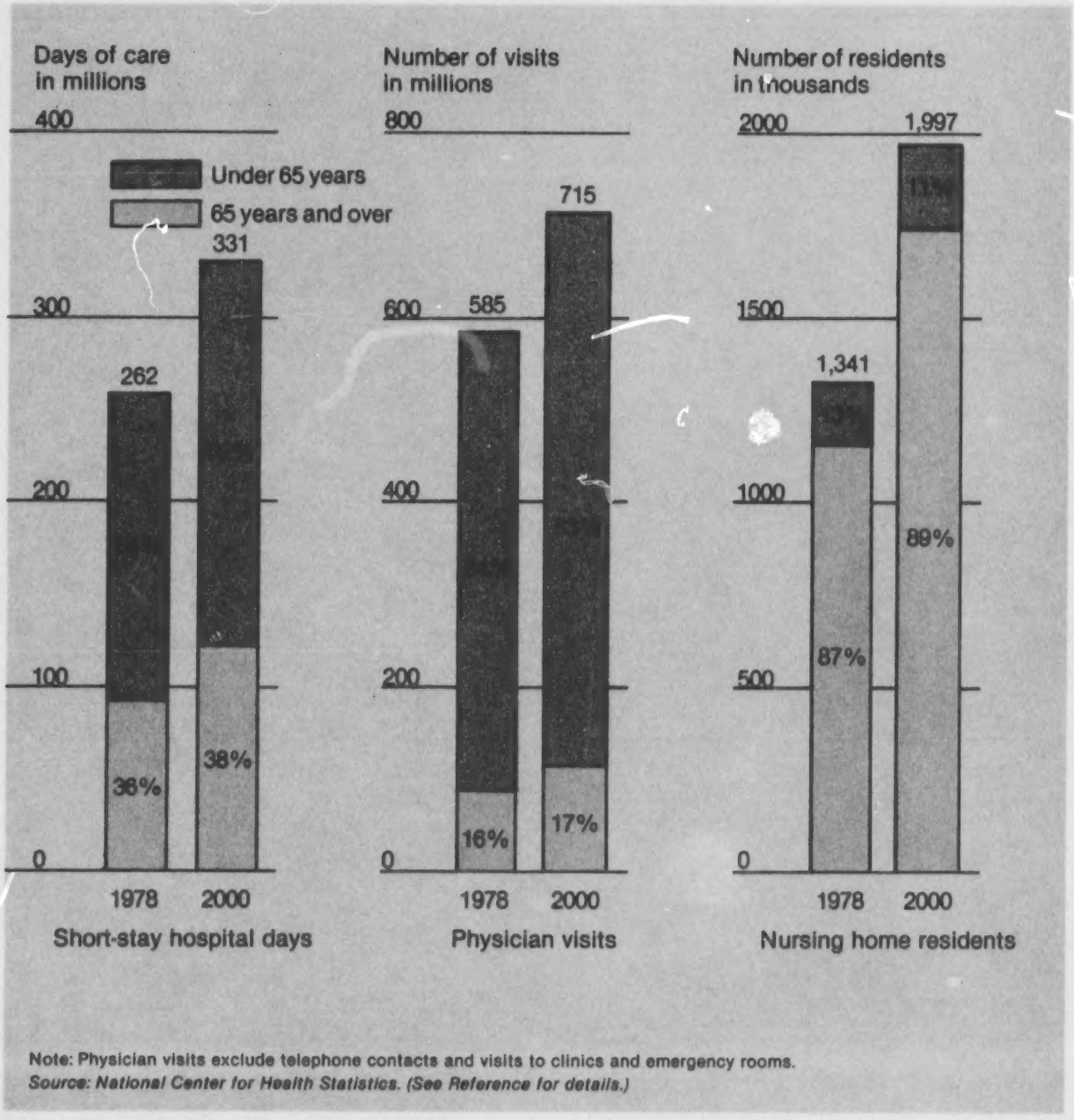
The growth in size of the elderly population will influence a growth in the use of health services by the elderly.

In 2000, the elderly will use 38 percent of the total 331 million days of short-stay hospital care projected for all ages combined. They will also make 17 percent of all visits to physicians' offices, by current projections.

The number of nursing home residents in the year 2000 will be almost 2 million, assuming current use rates, with 89 percent of the residents being age 65 and over. Because the nursing home population is predominantly elderly, use of nursing homes in 2000 is projected to be the fastest growing area in the health sector. Between 1978 and 2000, the nursing home population is expected to increase by 49 percent, while hospital days for persons of all ages will increase by 26 percent and physician visits by 22 percent.

Projections of the use of health services by the elderly: United States, 1978 and 2000.

(Chart III.8)



Note: Physician visits exclude telephone contacts and visits to clinics and emergency rooms.

Source: National Center for Health Statistics. (See Reference for details.)

IV Informal Support

Introduction

There are more elderly women than elderly men, and this fact shows up strikingly in their living arrangements. About 75 percent of elderly men, but only 37 percent of elderly women, live with their spouse. About 41 percent of elderly women live alone. And although this may mean greater independence, it also may cut them off from the form of assistance elderly people depend upon most—supports from family and friends in the household. Widows' chances of remarrying are dimmed not just by the relative scarcity of unmarried elderly men but also by the fact that men often opt for much younger marriage partners.

On the other hand, likelihood that future elderly will have children to call on for assistance is projected to increase over the next 30 years, as childlessness rates decline. Elderly persons generally have a considerable amount of contact with their children, perhaps contrary to common notions on this subject.

One basic measure of the responsibility which falls on working age adults is the ratio of number of children and elderly per 100 working age persons. Responsibility, as measured in this way, will decline across the next 30 years. At no time will the responsibility of working age adults be as great as it was in the late 1960's.

Some of the issues raised by data on informal supports include: Are family members available to provide assistance to impaired elderly relatives? Is such support likely to increase or decrease in the future? Will changes in family structure and work force participation of women increase the demand for *formal* long term care services? Will the responsibility which falls on working age adults to support children and the elderly increase or decrease in the future?

IV What are the living arrangements of the elderly?

One of the most striking phenomena of recent decades is the rapid growth in the number of elderly persons who live alone. Although living alone can mean greater independence, it also may mean being cut off from the most usual form of assistance, informal supports from spouse and family.

Since 1960, the number of elderly persons living alone has increased about three times as fast as would have been predicted from the simple growth in the size of the elderly population alone. The proportion living alone has increased from 19 percent of noninstitutionalized elderly in 1960 to 30 percent in 1979.

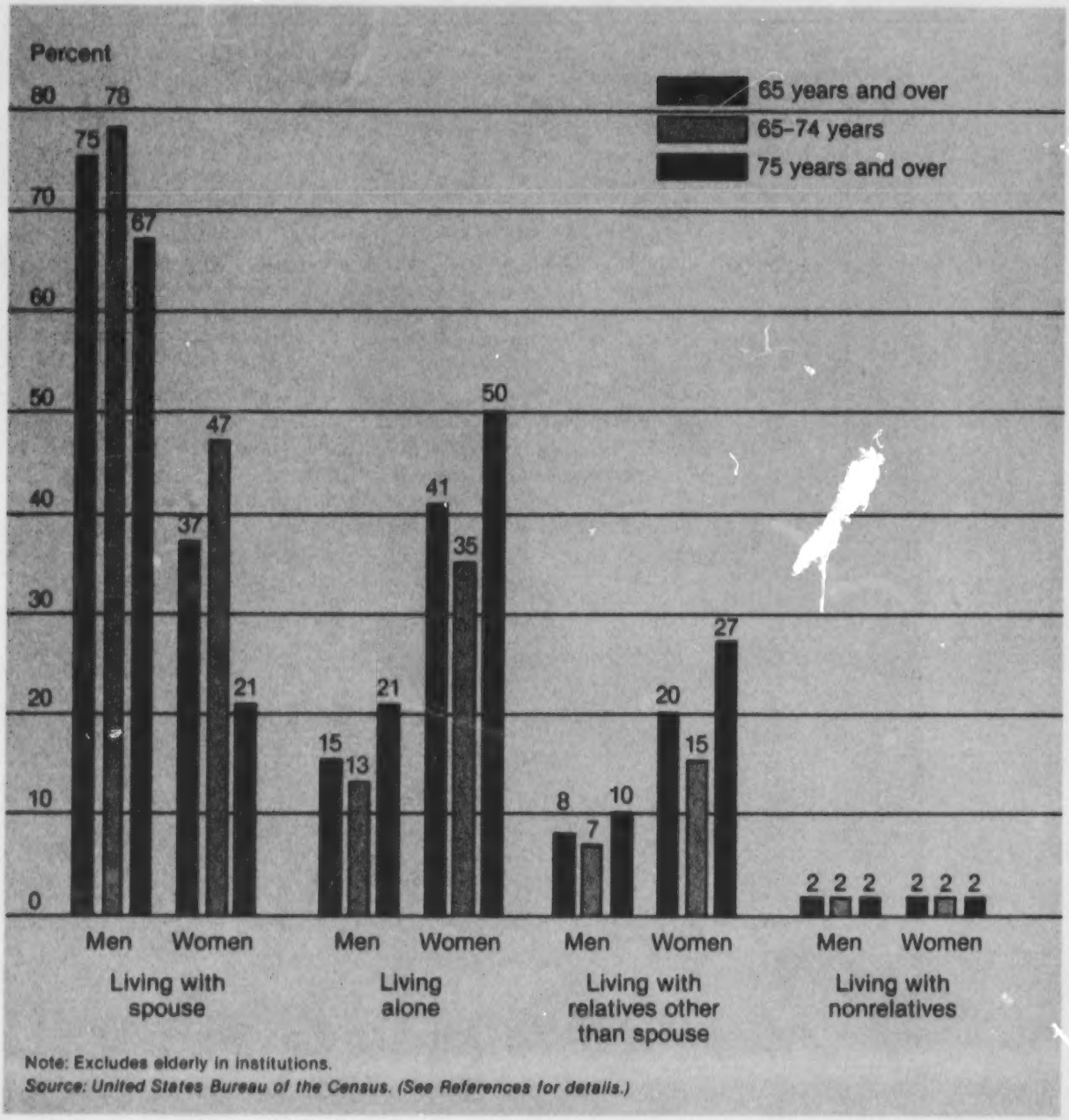
The trend toward living alone has been particularly noticeable among elderly women and the oldest subgroups of the elderly population. The number of elderly women maintaining households by themselves has grown by 3.5 million or 173 percent since 1960. The proportion of elderly women living alone has jumped from 24 to 41 percent. The increase in single-person households for both sexes 75 years and over has been twice as great as for the 65–74 age group.

About three-fourths of elderly men live with their wives, and another 8 percent live with other relatives such as children or brothers and sisters. Only 15 percent live alone. As elderly men grow older, they are somewhat less likely to have a spouse. Nevertheless, two-thirds of men 75 years or older live with their wives and only one-fifth live alone.

The proportion of elderly persons who live with nonrelatives is only 2 percent. Although some attention has focused on older men and women who live together without getting married in order to maintain higher Social Security benefits or decrease their income taxes, the number of such unmarried couples has remained stable at about 110,000 during the 1970's.

Living arrangements of the elderly: United States, 1979.

(Chart IV.1)



Note: Excludes elderly in institutions.

Source: United States Bureau of the Census. (See References for details.)

IV What is the marital status of the elderly?

Most elderly males are married (77 percent) whereas the majority of elderly women are widowed (52 percent). This difference is caused primarily by the shorter life expectancy for males (as shown in Chart II.4) and the fact that most men marry women younger than themselves. In addition, the remarriage rate is several times higher for elderly males than for females.

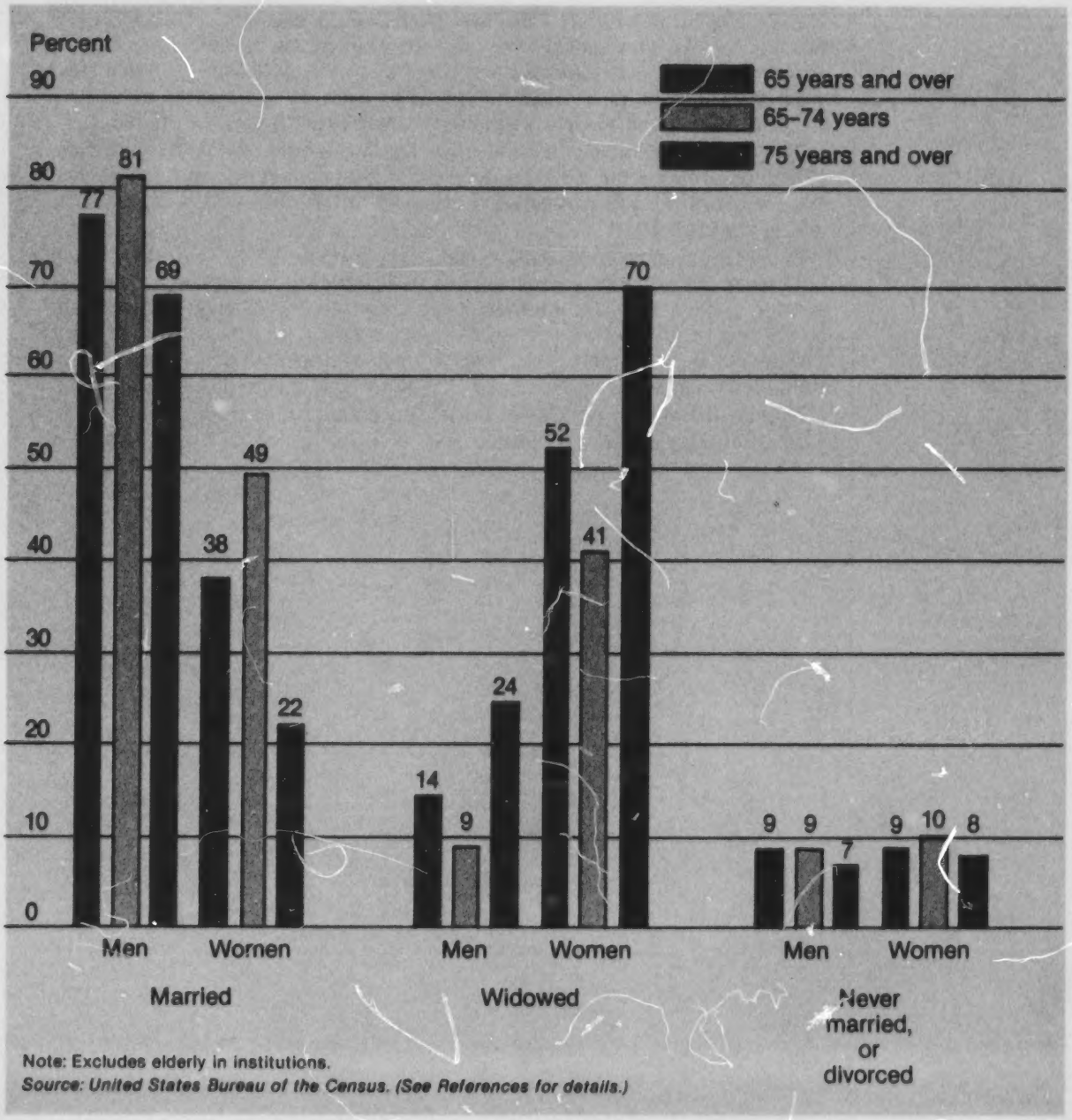
Thus, most women outlive their husbands, and they do so by many years. A widow in her 60's can expect to live another 15–20 years if current mortality rates hold constant.

The percentage of elderly persons who are married decreases sharply with age. For males, the proportion of those married drops from 81 percent in the 65–74 age group to 69 percent for men 75 and older. The decline is even steeper for women, falling from 49 to 22 percent.

Widows constitute 41 percent of women 65–74 years old and 70 percent of women 75 and older. They frequently suffer from multiple hazards of low income, failing health and social isolation.

Elderly persons who are currently divorced are relatively few in number. Only 3 percent of older men and women were so classified in 1979. However, the number of divorced elderly persons is increasing rapidly as younger generations with higher divorce rates reach their 65th birthdays.

Marital status of the elderly: United States, 1979.
(Chart IV.2)



Note: Excludes elderly in institutions.

Source: United States Bureau of the Census. (See References for details.)

IV What are the trends in marital status of the elderly?

Elderly people who are "married with spouse present" often have reduced needs for societal assistance as the spouse can often give needed support. Elderly men are more apt to be in this situation than are elderly women. About 75 percent of men over 65 are married-spouse present. Only 37 percent of elderly women are married with spouse present.

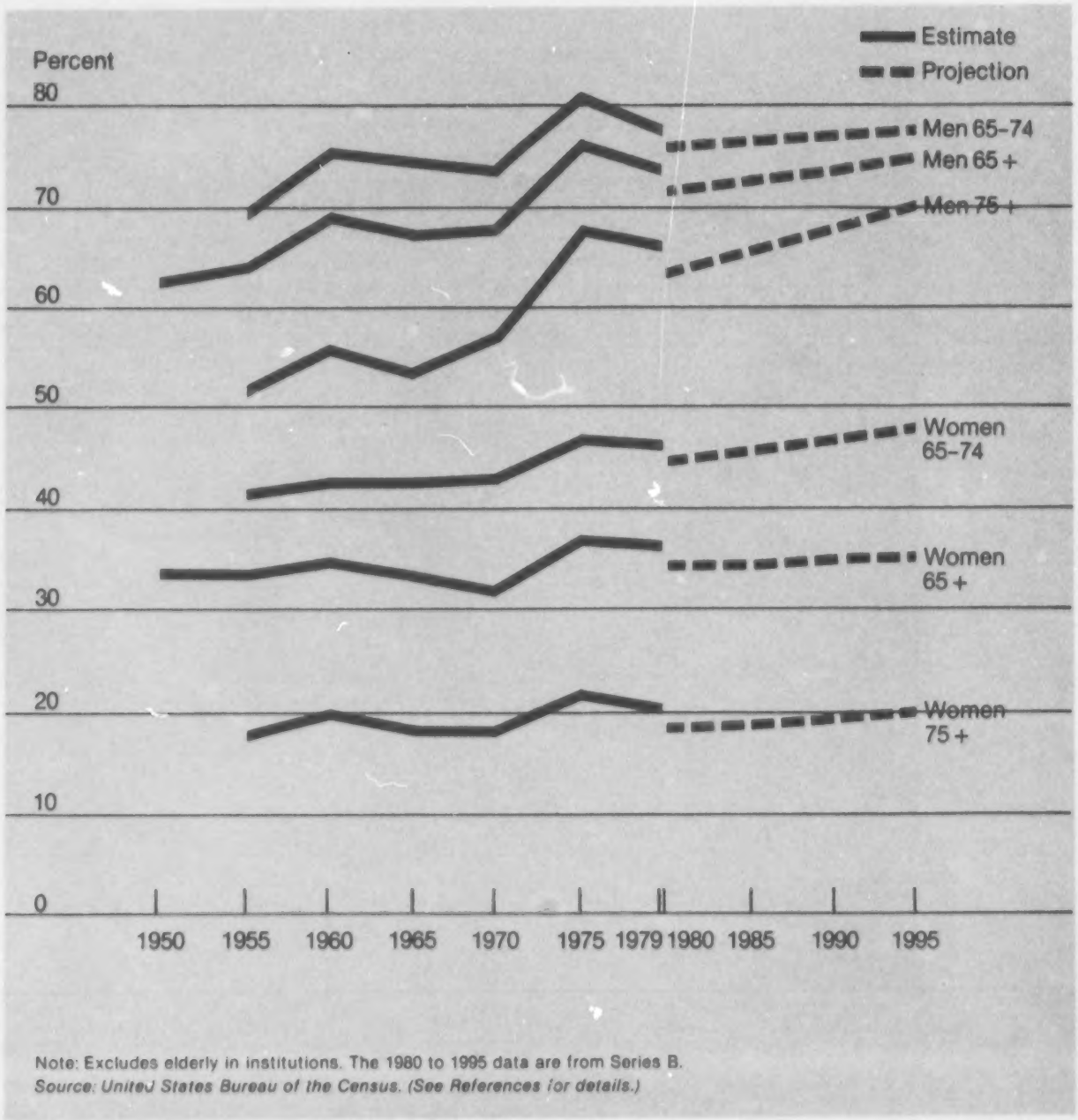
The differences broaden even more for those over 75. More than two-thirds of the men but only 21 percent of the women are married with spouse present. It is projected that these differences will continue to widen through 1995.

Several major factors explain the lower proportions of elderly women who are married-spouse present. Women live longer than men, and most women are married to men older than themselves. Elderly men are relatively few in number and when they remarry they often attract much younger marriage partners. Thus, women over age 75 are especially unlikely to remarry, as there are so few men over age 80 or 85.

Similar differentials exist in both White and Black populations. Elderly women of either group are much less likely to be married-spouse present than is true for men.

Percent of elderly who are married with spouse present by age groups and sex: United States, 1950–1995.

(Chart IV.3)



Note: Excludes elderly in institutions. The 1980 to 1995 data are from Series B.

Source: United States Bureau of the Census. (See References for details.)

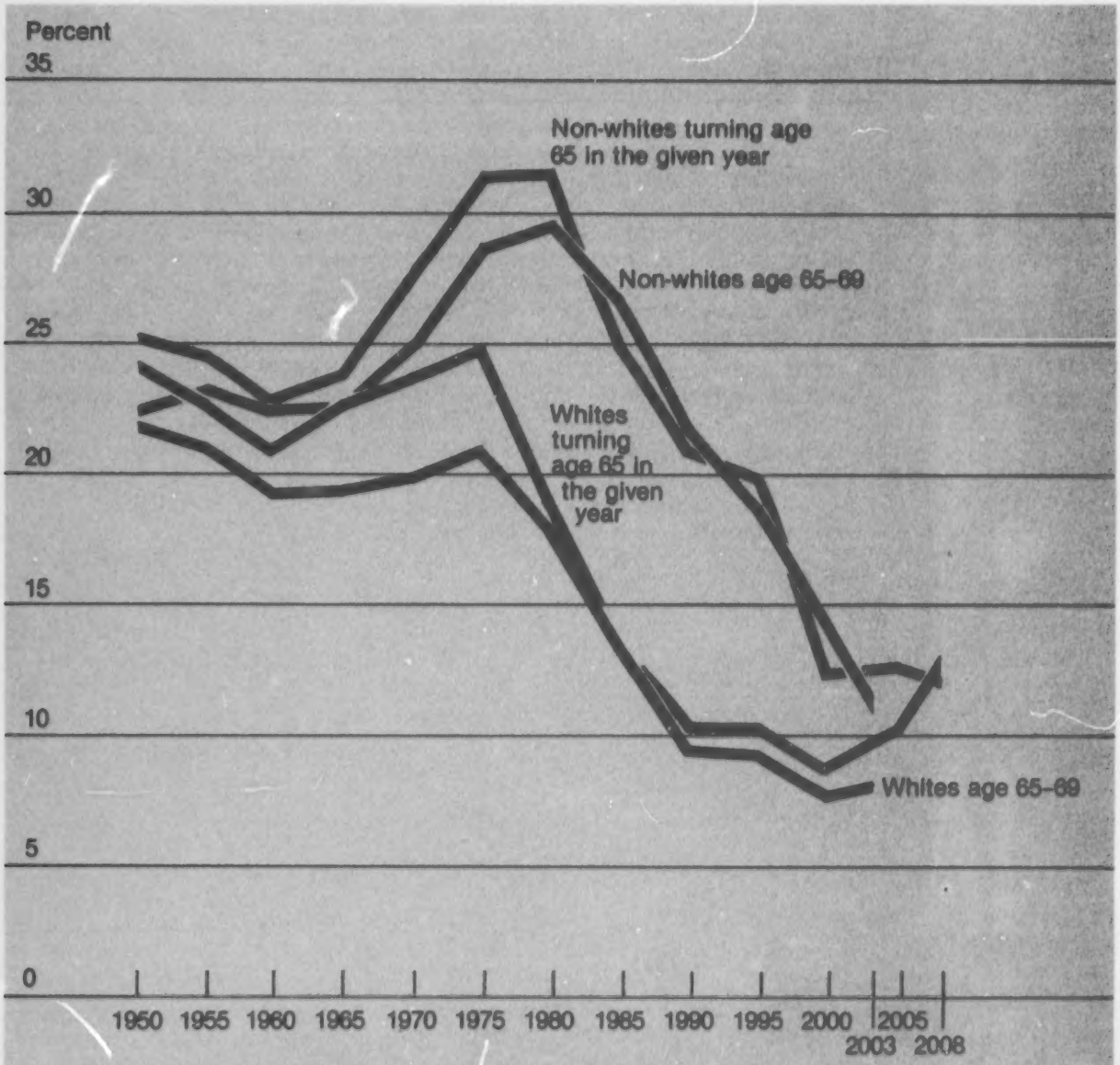
IV How many elderly women have no children?

Childlessness among elderly White women has been declining sharply since 1975. Childlessness among all other races of elderly women is at its peak now and will soon start to decline sharply. In 1980, about 18 percent of White women and 30 percent of all other women aged 65–69 were childless.

The sharp drop in childlessness now occurring means that a larger proportion of elderly women during the next 30 years should have progeny to help care for them. By 2000, less than 8 percent of White women and less than 15 percent of all other women aged 65–69 will be childless. At the end of the first decade of the next century, however, when the baby boom generation reaches old age, indications are that there will be a new rise in childlessness among elderly women.

Percent of elderly women who are childless by age and race: United States, 1950–2008.

(Chart IV.4)



Note: The data for the 65–69 year olds are actually for women aged 40–44 25 years prior to the dates shown. The data for those turning 65 are actually for 35 year olds 30 years prior to the dates shown.

Source: National Center for Health Statistics. (See References for details.)

IV Will most elderly have children to help them?

Children are the main source of informal support to elderly persons. The previous chart dealt with childless women, while this chart approximates the number of children ever born and relates them to the women who reach ages 65-69 along the time span from 1950-2010.

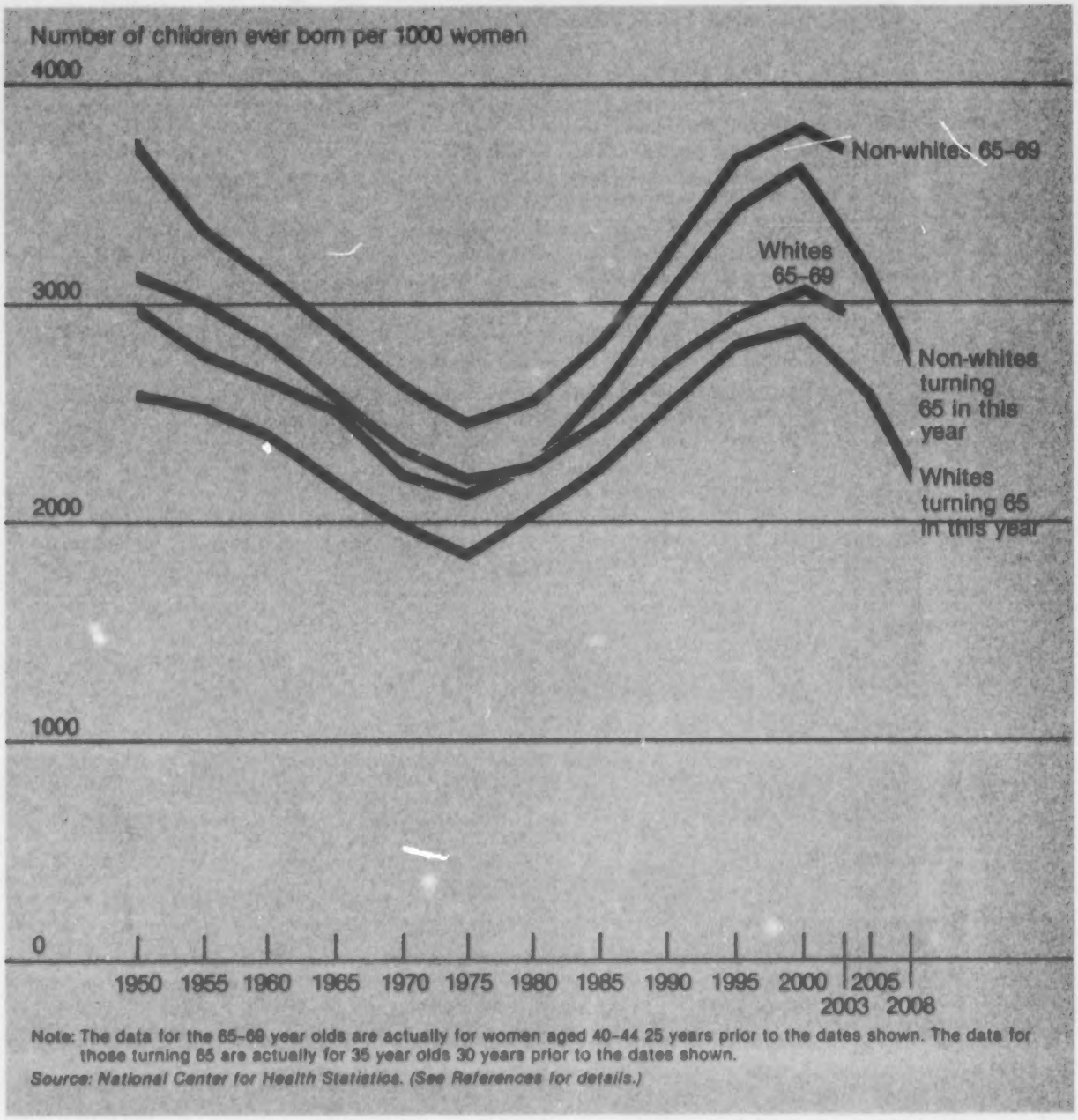
For women reaching ages 65-69 during the years 1950 to 1975, there was a sharp decline in the average number of children ever born to women in their age groups. By 1975, the lowest level was reached: White women 65-69 had an average of 2.2 children and all other races of women averaged 2.5 children. Since then, the average number of children per elderly woman has been rising sharply. It will continue to rise through 2000 when White women 65-69 will average 3.1 children and all other women about 3.8 children.

A sharp decline is projected after 2000. But not until at least 2010 will elderly women return to the small family sizes of the mid-1970's. It seems probable that the huge baby boom groups will not have very large numbers of children to help them when they become elderly.

All other women have higher levels of fertility than Whites and higher levels of childlessness, also (see Chart IV.4). What this means is that more White women become mothers but the women of other races who become mothers have larger families.

Average children ever born to elderly women by age and race: United States, 1950–2008.

(Chart IV.5)



Note: The data for the 65–69 year olds are actually for women aged 40–44 25 years prior to the dates shown. The data for those turning 65 are actually for 35 year olds 30 years prior to the dates shown.

Source: National Center for Health Statistics. (See References for details.)

IV How much contact do the elderly have with their children?

Contrary to a common notion that many elderly persons do not have frequent contact with their children, a recent nationwide survey indicates that most older people live relatively close to at least one of their children and that contacts with children are quite frequent.

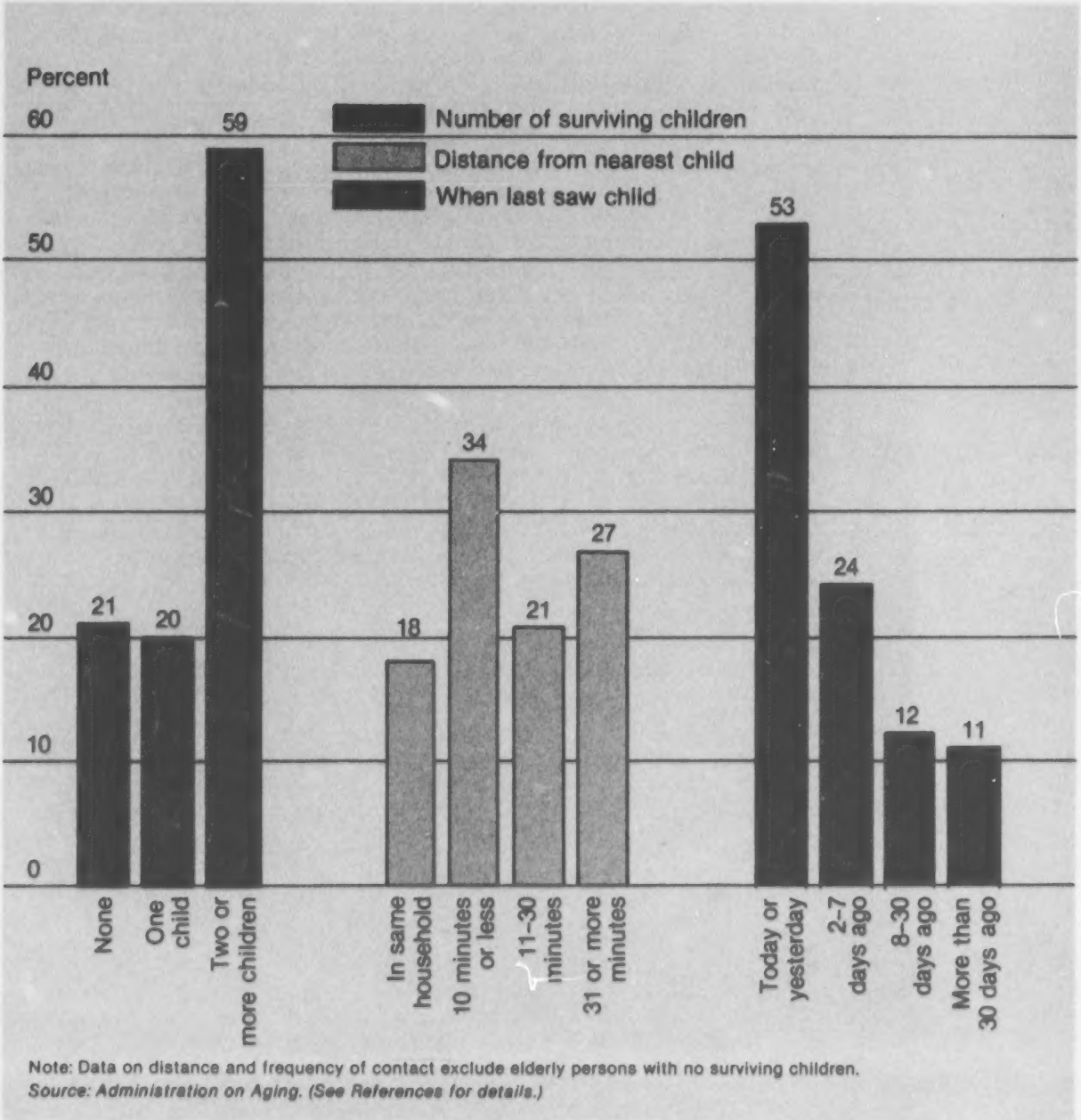
The survey shows that about four-fifths of elderly persons have one or more surviving children. Nearly three-quarters of those with children lived within 30 minutes' travel time of a child, including 18 percent who lived in the same household.

About three-fourths of elderly persons with surviving children saw one or more of their children within the week prior to the survey day, and only 11 percent had not seen a child in the previous month.

It is quite possible that frequency of contact with children will rise in the near future as the parents of the large baby boom generation of children enter the ranks of the elderly population.

However, after 2010 the elderly's frequency of contact with children may decine as the baby boom generation itself begins to reach age 65. This generation, which is now entering the prime child-bearing age and is experiencing the lowest fertility rates in the nation's history, will have fewer children to rely on for support.

Contacts by elderly with surviving children: United States, 1975.
(Chart IV.6)



Note: Data on distance and frequency of contact exclude elderly persons with no surviving children.
Source: Administration on Aging. (See References for details.)

IV Will the responsibility of supporting the elderly be too great for their families?

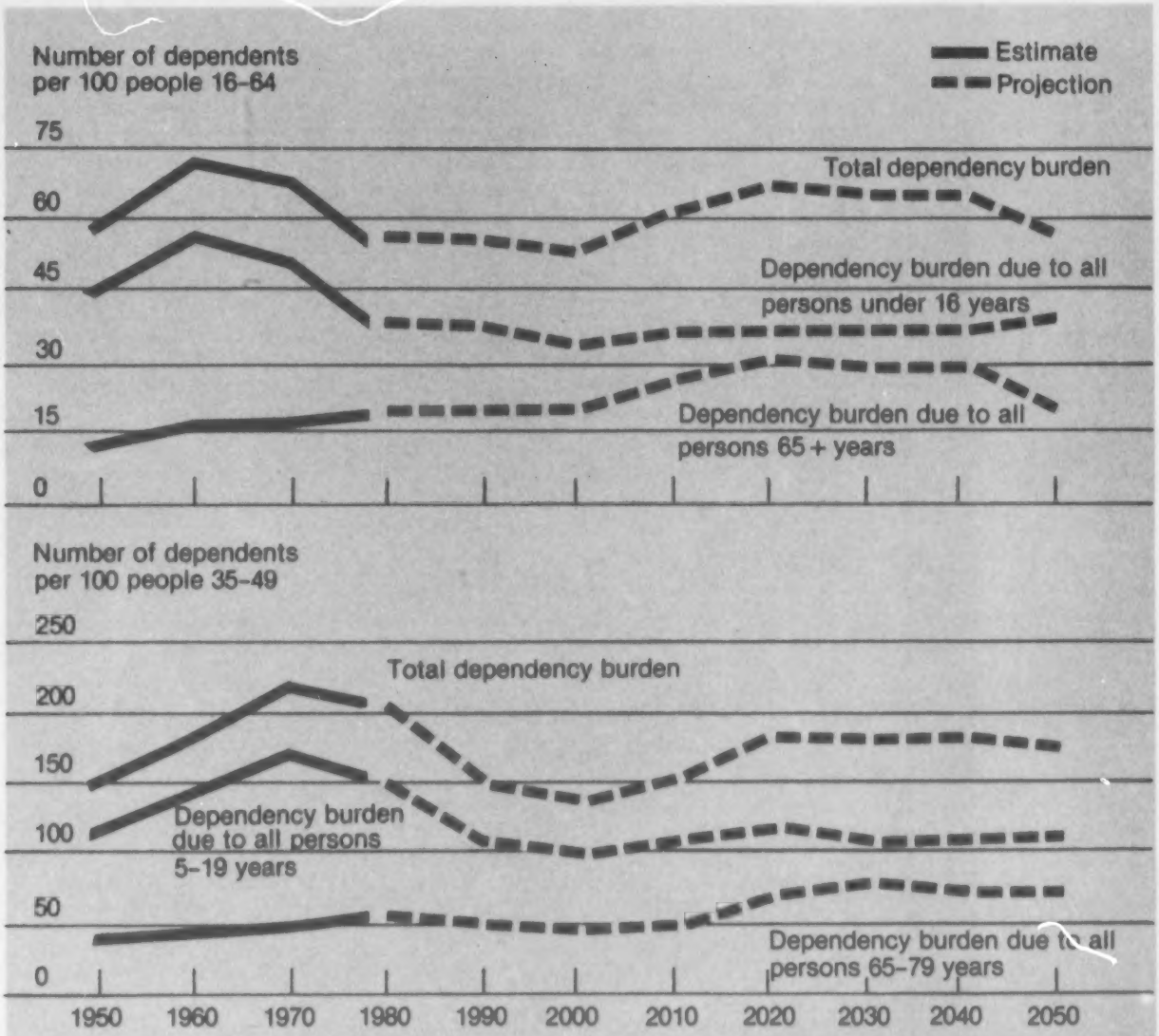
These two charts show how the responsibility of supporting children and elderly falls upon the working age group. Chart IV.7A shows the dependency ratio of people 16 to 64 years old. Chart IV.7B shows a similar ratio of people in the 35–49 age limits, who are in their prime working ages and who are often engaged simultaneously in raising children and supporting elderly parents.

The overall responsibility of the 16 to 64 group will be slightly lower in the next 30 years than at any time since World War II. At no time through 2050 will the overall responsibility of the 16 to 64 group be as great as it was in the 1960's. In fact, the peak of child dependency in 1960 will be almost as high as the 1980–2010 combined dependency for both children and elderly. After 2010 the total responsibility rises as the baby boom generation becomes elderly. However, it peaks considerably short of the 1960 total level. The dependency of the young population alone remains fairly stable from 1980 to 2050 in the Census Bureau projections.

For prime working age persons, aged 35 to 49, the change in the projected total dependency shown in Chart IV.7B is similar to the change on the wider working age group in Chart IV.7A. Their "double" responsibility was heaviest in the early 1970's and is now declining. This decline should bottom out toward 2000 and rise as the baby boom generation becomes elderly, reaching a plateau from 2020 to 2050 at a level considerably short of the 1970 level.

Number of dependents per 100 persons aged 16–64, 35–49: United States, 1950–2050.

(Chart IV.7)



Note: These data represent the entire census level legal population. They do not include any data from the 1980 Census.

Source: United States Bureau of the Census. (See References for details.)

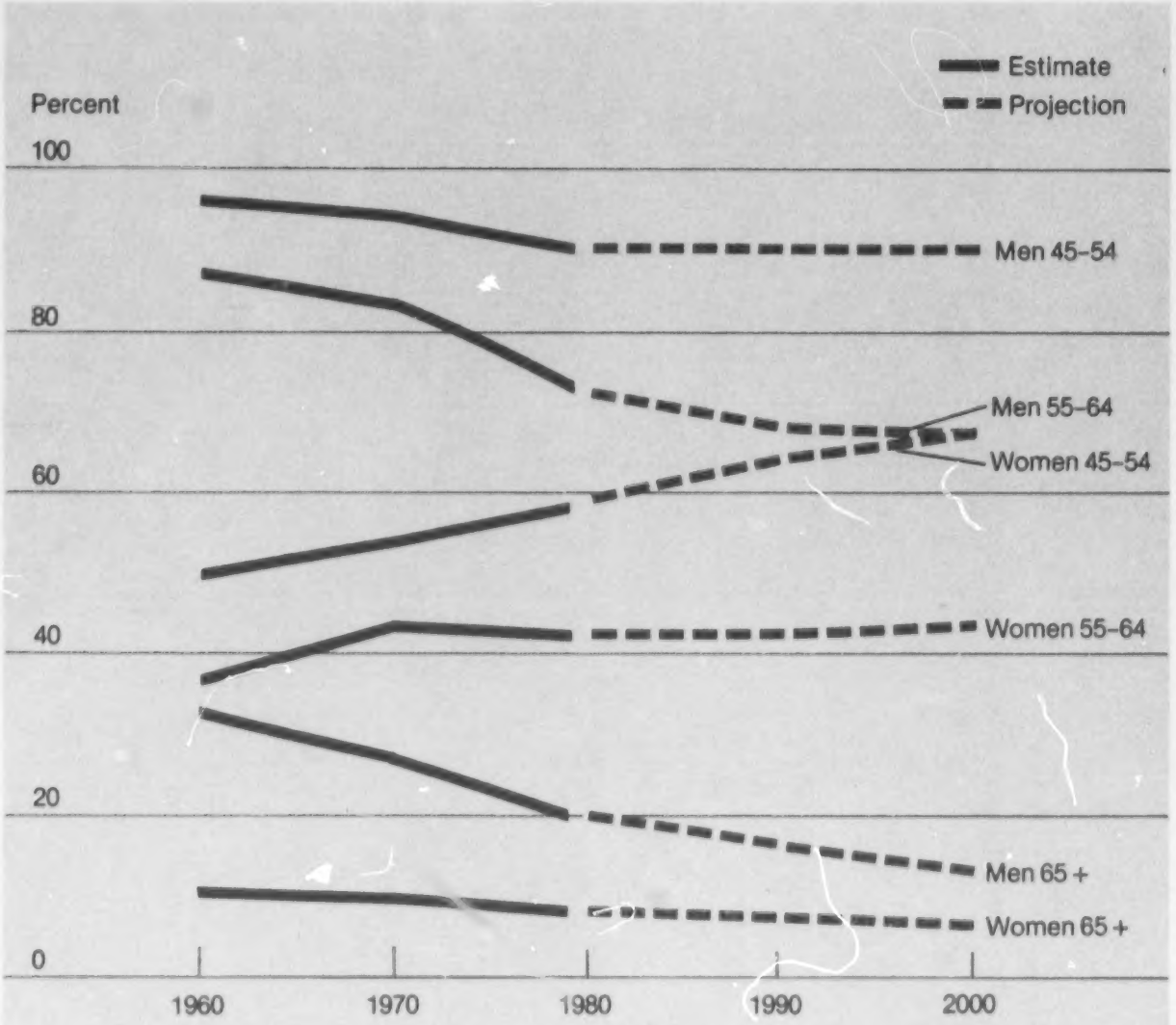
IV If more women work, will their assistance to the elderly decline?

There has been a steady decline in the participation of both elderly men and elderly women in the labor force for the last 30 years. This decline is expected to continue through 2000. However, in the 45-54 and 55-64 age groups, the picture is different for men and for women. Men are participating less in the labor force and this decline is projected to continue. Women 45-54 and 55-64, however, have been increasingly participating in the labor force since 1950, and this increase is projected to continue, especially for women in the 45-54 age group.

Women of these ages have traditionally contributed many hours to volunteer community service and informal support of elderly persons in their families and communities. The women-working trend portends that such help may not be as readily available in the future. (See text for Chart III.7 for a discussion of impacts on health care costs.) However, the trend also signifies greater financial independence for women and may reduce the proportion of low-income women living alone.

Percent of persons in the labor force by age groups and sex: United States, 1960–2000.

(Chart IV.8)



Note: Data are for the civilian non-institutional population. The labor force includes both the employed and the unemployed.
Source: United States Bureau of the Census and the Bureau of Labor Statistics. (See References for details.)

V Federal Policies

The Impact of Federal Policies on Long Term Care

The problems and difficulties in the delivery of long term care stem from the overall pattern of Federal policies and programs and the technical requirements associated with them. Although many good things are accomplished by these programs, they never seriously address the central problems of long term care. Every program and every funding resource relates to something else—a particular diagnosis, specific income, a special type of building assistance. Each of the programs is limited, restricted and focused primarily on some purpose other than the delivery of long term care to the people who need it.

The programs which are used to assist elderly frail and vulnerable persons and others in need of long term care have developed incrementally, adding new programs without changing or adjusting those already in operation. It is evident that this piecemeal growth has had the effect of scattering, distorting and impeding the delivery of long term care.

The delivery of long term care services, as it now operates, has three major features:

(1) It is dominated by the Medicaid program and thus stresses medical and institutional care rather than community-based social and support services for people with chronic functional disabilities. Many personal hardships result from this medical, institutional bias. Some elderly persons are moved unnecessarily from their homes and neighborhoods where they want to stay, to institutions where they do not want to go. Family resources are depleted by Medicaid's "spend down" provisions to the point where individuals may have no home left to go to when they are discharged from the institution. Medicaid redeterminations of eligibility frequently interrupt or interfere with continuity of care.

(2) A second feature of the current delivery of long term care services is that it is built on Federal programs none of which makes provision for assessing the overall needs of persons requiring long term care. The Supplemental Security Income program (SSI) makes cash payments to eligible persons, but stops there. SSI eligibility determinations generally do not assess the total needs of recipients or arrange for services. Assisted housing programs also generally operate as a form of income assistance, rather than as points for bringing together the services required by frail and vulnerable persons. Programs of income assistance, housing assistance and medical care look at only one or two aspects of the individual's needs. Furthermore, eligibility for each program has to be determined separately, under separate critiera, instead of determining individual eligibility for these and other government and non-government programs at the time the person needing long term care enters the system.

When these programs are combined to delivery long term care to the individual, the service philosophy essential to social support programs is

lacking. Some improvement may now be on the way, however, in the housing field as a number of small congregate housing demonstrations with service supports take shape.

(3) Finally, the third feature is that the efforts to develop community-based services under Title III of the Older Americans Act and Title XX of the Social Security Act have not yet achieved either the volume of services or the specific focus on long term care which might make such services a major element in the delivery of long term care. Positive steps are being made, however, towards better understanding of how to use resources in ways which respond to the needs of impaired and disabled persons; i.e., the new long term care demonstration projects and university gerontology centers being developed by a combination of programs within the Department of Health and Human Services.

The basic problem long term care efforts face is that programs and available resources cannot easily be coordinated or combined in a way that specifically focuses on the individual. Each of the closely-related programs dealing with income assistance, physical and mental conditions and housing has different goals and varying eligibility criteria, and none of the programs has the broad goal of sustaining the impaired individual in the community.

The FCA's efforts to focus on the special needs of the frail elderly and on identifying key issues in long term care can be applied to the reform and redesign of social and health programs. Proposals should be measured against goals of long term care: Will proposed measures promote community care? Will they encourage continuity of care? Will they enhance the natural support which elderly persons receive from family and friends? Will they encourage service-supported housing programs?

As the nation tries to understand and know what to do about long term care, the age groups most at risk for such care continue to grow far faster than any other age groups. The death rate among very old Americans, 85 years old and older, has declined dramatically in the last decade. The demographic factors traced in the first section of this chartbook bear importantly upon the issues of long term care because the incidence of illness, isolation and poverty increases with age.

The person in need of long term care has been defined by the Federal Council on the Aging as one who because of physical and/or mental conditions is unable to cope with the tasks of daily living without assistance for extended periods of time.

Much of the long term care elderly persons receive comes not from formal services but from the informal support of family and friends. However, when such help is unavailable or no longer adequate, intervention by formal or public programs is indicated.

The FCA has adopted the position that the multiple health and social needs of the at-risk elderly require coordination in the delivery of medical and social services. Medical services should reach all whose primary need is a medical regime, either in their home or in a medical facility. Social services should be available to all whose primary need is assistance in coping with daily living. Medical and social services should be coordinated to provide care over the long term that is appropriate, balanced and supportive.

Current Federal programs finance a variety of long term care services at local levels, primarily under Titles XVIII, XIX and XX of the Social Security Act (Medicare, Medicaid and Social Services) and Title III of the Older Americans Act (social and nutrition services and senior centers). Medicaid, Title XX and Title III are State-administered while Medicare is Federally-administered. Income maintenance is provided mainly through the Supplemental Security Income program and Old Age, Survivors and Disability Insurance, both Federally-administered. Building-oriented programs are operated by the Department of Housing and Urban Development, often under State and local administration. Although all these programs contribute to long term care, the system itself has evolved primarily within the locus of medical service because that is where Federal funding support could be found for such programs.

The FCA has taken the position that health dollars should not be spent for the social services which constitute a major part of long term care. However, unless alternative ways are developed to meet the long term care needs of the at-risk elderly, there will be continuing pressure to expand the use of medical services under Title XIX (Medicaid) to finance long term care.

Any consideration of the subject should start with the perception that there are many individuals who cannot be cured by medical intervention in a matter of days, weeks or months, and that the system itself will cause problems if it is not responsive to those individuals and their needs over a long period of time. Institutional care is often used inappropriately in these cases because Medicaid will pay the full cost of institutional care in some circumstances but will almost never pay for social services in a non-institutional setting.

There is a major gap in national social service data on the elderly available for planning and policy-making in long term care. No statistics are available on social services which would be comparable to those available on health services. Such data as are available on social services are limited to programs under Title XX of the Social Security Act and Title III of the Older Americans Act. Title XX reporting is weighted towards children's programs and lacks statistical reporting by other age groups. Some data are available on Title III costs and program areas under the

Older Americans Act, such as in-home services, but little information is available on how fully such services meet the needs of impaired older people. There is also a lack of adequate data on the number of older persons in need of mental health services or the number of those receiving them. All of these gaps taken together add up to an overall picture in which there is no solid information on the total number of older persons needing and receiving social services and mental health care.

These are some of the major problems besetting any efforts to reach a public policy stance on long term care. Another set of difficulties stand in the way of anyone working directly with impaired and disabled elderly people who tries to combine the programs to respond to the individual's needs. These are the technical requirements of each program.

SSI reduces benefits for beneficiaries living with others, creating a situation where a family with an impaired member may be better off economically if that member is placed in a nursing home. The program provides no extra payment for domiciliary care of a mildly disabled person. Rather than supplementing the Federal payment with State funds, some States may place these individuals in intermediate care facilities.

Payments under SSI are reduced when cash or in-kind contributions are received by a beneficiary who is living independently. This may discourage cash gifts and regular in-kind contributions from relatives.

A payment of $25 a month is made by SSI to individuals in Medicaid nursing homes. This amount is supplemented by some States. However, non-SSI nursing home residents must pay toward the cost of institutional care if their incomes exceed $25 a month. In this situation, it becomes almost impossible to return home because the individual's funds have been utilized to pay for institutional care.

Cash assistance to married couples is reduced when one spouse is institutionalized under Medicaid requirements. The non-institutionalized spouse may then be unable to maintain himself/herself and usually has to give up the home. Rules for couples receiving Medicaid but not SSI require a similar reduction in income. In these instances, not only must the institutionalized spouse manage on less money, but also the possible return of the institutionalized spouse to his/her home is in jeopardy because of lack of funds.

Assets of SSI and Medicaid recipients cannot be above minimum levels. By using all their savings to pay for initial months in a nursing home, individuals then may become eligible for Medicaid. However, they are then left with no funds to return home should they be able to do so.

Medicaid eligibility requirements differ for home health care and for institutional care. The income standards are higher for persons in nursing

homes than for those living at home or in congregate housing. These eligibility factors create a bias towards nursing homes; i.e., individuals with too much income for Medicaid eligibility at home or in congregate housing may become eligible for institutional services even though community-based services may be available and more appropriate.

The Medicaid "spend-down" contributes to a depletion of resources. Periodic redeterminations of eligibility make it difficult to plan care since individuals go off and on the Medicaid rolls during each period of eligibility; i.e., individuals do not become eligible until they "spend-down" and they are then eligible for the remainder of that eligibility period. This results in a loss of continuity of care.

There is a limit on home health benefits under Parts A and B of Medicare. In addition, the hospitalization requirement under Part A limits benefits. The "homebound" requirement is geared to skilled care and not to services which relate to daily life activities and social supports. The definition of homebound makes it difficult to provide needed in-home services.

These are some of the problems in coordinating services to meet the needs of the frail and vulnerable. The public policy debate now must determine how to make the delivery of long term care services more responsive to the needs of those requiring such care. The response becomes more pressing as the at-risk population grows.

References
Appendixes

Demographics

Chart I.1
U.S. Bureau of the Census, *Current Population Reports*, Series P-25, No. 311, "Estimates of the Population of the United States, by Single Years of Age, Color, and Sex: 1900–1959", 1965.

U.S. Bureau of the Census, *Current Population Reports*, Series P-25, No. 519, "Estimates of the Population of the United States, by Age, Sex, and Race: April 1, 1960 to July 1, 1973", 1974.

U.S. Bureau of the Census, *Current Population Reports*, Series P-25, No. 704, "Projections of the Population of the United States: 1977 to 2050", 1977.

U.S. Bureau of the Census, *Current Population Reports*, Series P-25, No. 870, "Estimates of the Population of the United States, by Age, Race and Sex: 1976 to 1979", 1980.

Chart I.2
The same sources as those of Chart I.1 were used through the year 2000. Information after that time is from unpublished Census Bureau tabulations. The 1950 data for Blacks were estimated from the 1950 data for non-whites.

Chart I.3
The same sources as those of Chart I.1 were used.

Chart I.4
The same sources as those of Chart I.1 were used.

Chart I.5
U.S. Bureau of the Census, *Current Population Reports*, Series P-25, No. 875, "Estimates of the Population of States, by Age: July 1, 1971 to 1979", January 1980, Tables 4 and 5.

Chart I.6
U.S. Bureau of the Census, *Current Population Reports*, Series P-20, No. 121, "Educational Attainment: March 1962", 1963, Table 1.

U.S. Bureau of the Census, *Current Population Reports*, Series P-20, No. 207, "Educational Attainment: March 1970", 1970, Table 1.

U.S. Bureau of the Census, *Current Population Reports*, Series P-20, No. 356, "Educational Attainment in the United States: March 1979 and 1978", 1980, Table 1.

The source of the projected values are unpublished projections prepared by the U.S. Bureau of the Census.

Chart I.7
U.S. Bureau of the Census, *Current Population Reports*, Series P-60, No. 124, "Characteristics of the Population Below the Poverty Level: 1978", 1980.

Chart I.8
U.S. Bureau of the Census, *Current Population Reports*, Series P-60, No. 123, "Money Income of Families and Persons in the United States: 1978", U.S. Government Printing Office, Washington, DC, 1980, Tables 34 and 35, pp. 152-155.

Chart I.9
U.S. Bureau of the Census, *Current Population Reports*, Series P-60, No. 124, "Characteristics of the Population Below the Poverty Level: 1979", U.S. Government Printing Office, Washington, DC, 1980, Table 1, p. 16.

Chart I.10
U.S. Bureau of the Census, *Current Population Reports*, Series P-60, No. 124, "Characteristics of the Population Below the Poverty Level: 1979", U.S. Government Printing Office, Washington, DC, 1980, Table 2, p. 19.

Chart I.11
U.S. Bureau of the Census, *Current Population Reports*, Series P-60, No. 124, "Characteristics of the Population Below the Poverty Level: 1979", U.S. Government Printing Office, Washington, DC, 1980, Table 1, pp. 17-18.

Chart I.12
U.S. Bureau of the Census, *Current Population Reports*, Series P-60, No. 124, "Characteristics of the Population Below the Poverty Level: 1979", U.S. Government Printing Office, Washington, DC, 1980, Table 1, pp. 17-18.

Health Status

Chart II.1
National Center for Health Statistics, Illness and Disability Statistics Branch, Division of Health Interview Statistics: Unpublished data from the 1978 National Health Interview Survey.

For basic data on this topic see: National Center for Health Statistics: Current Estimates from the Health Interview Survey, United States, 1978, by Jimmie D. Givens. *Vital and Health Statistics.* Series 13, No. 130. DHEW Pub. No. (PHS) 80-1551. Public Health Service. Washington. U.S. Government Printing Office, November 1979.

Chart II.2
National Center for Health Statistics, Illness and Disability Statistics Branch, Division of Health Interview Statistics: Unpublished data from the 1978 National Health Interview Survey.

Chart II.3
Federal Council on Aging: *Mental Health and the Elderly, Recommendations for Action,* 1977 Report of the Secretary's Committee on Mental Health and Illness of the Elderly, U.S. Department of Health, Education and Welfare, DHEW Publication No. (OHDS) 80-20960, November 1979.

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Chart II.4
1978 ESTIMATES:
National Center for Health Statistics: Final Mortality Statistics, 1978. *Monthly Vital Statistics Report,* Vol. 29, No. 6. DHHS Pub. No. (PHS) 80-1120, Public Health Service, Hyattsville, MD., September 17, 1980.
2000 ESTIMATES:
Social Security Administration, Office of the Actuary: United States Population Projections for OASDI Cost Estimates, 1980. Actuarial Study No. 82, Pub. No. (SSA) 11-11529, June 1980.
2050 ESTIMATES:
These numbers are estimated from the above Social Security Administration Actuarial Study.

Chart II.5
Fries, J. F., "Aging, Natural Death and the Comparison of Morbidity", *New England Journal of Medicine,* Vol. 303, No. 3, July 1980, pg. 130–135.

Use of Health Services

Chart III.1

Hospital discharge rates are based on the number of hospital discharges divided by the number of people in the civilian population for the appropriate year cited.

HOSPITAL DISCHARGE DATA:

National Center for Health Statistics: Utilization of short-stay hospitals, summary of nonmedical statistics, United States, 1965, by M. G. Sirken. *Vital and Health Statistics.* PHS Pub. No. 1000, Series 13, No. 2. Public Health Service. Washington. U.S. Government Printing Office, August 1967.

National Center for Health Statistics: Utilization of short-stay hospitals, summary of nonmedical statistics, United States, 1973, by W. Frank Lewis. *Vital and Health Statistics.* Series 13, No. 23. DHEW Pub. No. (HRA) 76-1774. Public Health Service. Washington. U.S. Government Printing Office, July 1976.

National Center for Health Statistics: Utilization of short-stay hospitals, annual summary for the United States, 1978, by Barbara J. Haupt. *Vital and Health Statistics.* Series 13, No. 46. DHEW Pub. No. (PHS) 80-1797. Public Health Service. Washington. U.S. Government Printing Office, March 1980.

Discharge data on the more detailed age breaks above 65 years and over are from:

Hospital Care Statistics Branch, Division of Health Care Statistics: Unpublished data from the National Hospital Discharge Survey.

POPULATION DATA:

Population data used in calculating the hospital discharge rates are from the following Census Bureau publications:

U.S. Bureau of the Census, *Current Population Reports,* Series P-25, No. 519, "Estimates of the Population of the United States by Age, Sex, and Race: April 1, 1960 to July 1, 1973", April 1974.

U.S. Bureau of the Census, *Current Population Reports,* Series P-25, No. 721, "Estimates of the Population of the United States by Age, Sex and Race: 1970 to 1977", April 1978.

U.S. Bureau of the Census, *Current Population Reports,* Series P-25, No. 870, "Estimates of the Population of the United States by Age, Race and Sex: 1976 to 1979", January 1980.

Chart III.2
National Center for Health Statistics: Nursing Home Residents: Utilization, Health Status and Care Received, 1977 National Nursing Home Survey, by Esther Hing, *Vital and Health Statistics*, Series 13, No. 51, DHHS Pub. No. (PHS) 81-1712, Public Health Service, Washington, U.S. Government Printing Office, In press.

Chart III.3
Physician visits per person are based on the number of visits divided by the number of people in the civilian population.

PHYSICIAN VISITS DATA:
Ambulatory Care Statistics Branch, Division of Health Care Statistics: Unpublished data from the 1978 National Ambulatory Medical Care Survey.

POPULATION DATA:
U.S. Bureau of the Census, *Current Population Reports*, Series P-25, No. 870, "Estimates of the Population of the United States, by Age, Race and Sex: 1976 to 1979", January 1980.

Chart III.4
"Demography and Mental Health Care of the Aged", R. Redick and C. Taube, *Handbook of Mental Health Care and Aging*, ed. J. Birren and R. Sloane, 1980, Prentice Hall, Inc., Englewood Cliffs, NJ.

Chart III.5
"Demography and Mental Health Care of the Aged", R. Redick and C. Taube, *Handbook of Mental Health Care and Aging*, ed. J. Birren and R. Sloane, 1980, Prentice Hall, Inc., Englewood Cliffs, NJ.

National Center for Health Statistics: The National Nursing Home Survey: 1977 Summary for the United States, by J. Van Nostrand, *et al*, *Vital and Health Statistics*, Series 13, Number 43. DHEW Publication No. (PHS) 79-1794, Public Health Services, Washington, U.S. Government Printing Office, July 1979.

Hospital Care Statistics Branch, Division of Health Care Statistics: Unpublished data from the National Hospital Discharge Survey.

Chart III.6
Health Care Financing Administration, *Health Care Financing Review/ Spring 1980*. "Differences by Age Groups in Health Care Spending", C. R. Fisher, pg. 65-90.

Chart III.7
Health Care Financing Administration, *Health Care Financing Review/ Winter 1980*. "Projections of National Health Expenditures, 1980, 1985, and 1990", M. Freeland *et al*, pg. 1-27.

Chart III.8
Numbers are derived by applying age-specific utilization rates estimated by the 1978 National Hospital Discharge Survey, the 1978 National Ambulatory Care Survey, and the 1977 National Nursing Home Survey to projected populations in the year 2000.

PROJECTED POPULATION DATA:
U.S. Bureau of the Census, *Current Population Reports,* Series P-25, No. 704, "Projections of the Population of the United States: 1977 to 2050", July 1977.

Informal Support

Chart IV.1
U.S. Bureau of the Census, *Current Population Reports*, Series P-20, No. 349, "Marital Status and Living Arrangements: March 1979", February 1980, Tables 1, 2 and 6.

Chart IV.2
U.S. Bureau of the Census, *Current Population Reports*, Series P-20, No. 349, "Marital Status and Living Arrangements: March 1979", February 1980, Table 1.

Chart IV.3
U.S. Bureau of the Census, *Current Population Reports*, Series P-20, No. 349, "Marital Status and Living Arrangements: March 1979", 1980.

U.S. Bureau of the Census, *Current Population Reports*, Series P-20, No. 287, "Marital Status and Living Arrangements: March 1975", 1975.

U.S. Bureau of the Census, *Current Population Reports*, Series P-20, No. 212, "Marital Status and Family Status: March 1970", 1971.

U.S. Bureau of the Census, *Current Population Reports*, Series P-20, No. 144, "Marital Status and Family Status: March 1965", 1965.

U.S. Bureau of the Census, *Current Population Reports*, Series P-20, No. 105, "Marital Status and Family Status: April 1955", 1955.

U.S. Bureau of the Census, *Current Population Reports*, Series P-25, No. 805, "Projections of the Number of Households and Families: 1979 to 1995", 1979.

Charts IV.4 and IV.5
The source of the projected values are unpublished projections prepared by the U.S. Bureau of the Census. They are derived from the following information:

1. Robert Heuser. "Fertility Tables for Birth Cohorts by Color: United States, 1917-75". DHEW Publication No. (HRA) 76-1152, 1976.
2. Continuations of the above data set are available in:
   a. 1974—National Center for Health Statistics. *Vital Statistics of the United States, 1974*, Volume I—Natality, 1978.
   b. 1975—National Center for Health Statistics. *Vital Statistics of the United States, 1975*, Volume I—Natality, 1978.
   c. 1976 to 1978—Unpublished data from the National Center for Health Statistics, Division of Vital Statistics.

Chart IV.6
Administration on Aging, *National Survey of the Aged, Final Report*, prepared by Ethel B. Shanas, Department of Sociology, University of Illinois at Chicago Circle, under project number HEW OHD 90-A-369 (no date given), Tables 6-7A, 6-8A, 6-11A and 7-1A.

Chart IV.7A

U.S. Bureau of the Census, *Current Population Reports,* Series P-25, No. 311, "Estimates of the Population of the United States, by Single Years of Age, Color, and Sex: 1900–1959", 1965.

Chart IV.7B

The same sources as those of Chart I.1 were used through the year 2000. Information after that time is from unpublished Census Bureau tabulations. The 1950 data for Blacks were estimated from the 1950 data for all other races.

Chart IV.8

U.S. Bureau of the Census. Historical Statistics of the United States, Colonial Times to 1970, Bicentennial Edition, Part 2, 1975.

U.S. Bureau of the Census, *Current Population Reports,* Series P-20, No. 100, "A Statistical Portrait of Women in the United States: 1978", 1980.

U.S. Bureau of the Census, *Current Population Reports,* Series P-20, No. 350, "Population Profile of the United States: 1979", 1980.

The 1980 to 2000 figures are from the middle series of unpublished Bureau of Labor Statistics projections.

Appendix I

Long Term Care Work Group

Members—1979

Action
Suzanne Fahy

Community Services Administration
Linda McCabe

Department of Agriculture
Joyce Berry, Ph.D.

Department of Health and Human Services
Harry Posman, Ph.D.
Administration on Aging
James Burr
Administration for Public Services
Janice Caldwell, Ph.D.
Ruth Fosler
Bernice Harper
Mel Merchant
Carol Rubin
Health Care Financing Administration
Faye G. Abdellah, Ph.D.
Office of the Assistant Secretary for Health
Mary Harahan
Office of the Assistant Secretary for Planning and Evaluation
Joan F. Van Nostrand
National Center for Health Statistics
Carol Ludwig, M.D.
National Institute on Aging
Eleanor Friedenberg
National Institute of Mental Health

Department of Housing and Urban Development
Jerry Nachison

Domestic Policy Council
Diana Elmes

General Accounting Office
Janet Shikles

Office of Management and Budget
Kathy Yarbrough

Veterans Administration
Ralph Goldman, M.D.

Federal Council on the Aging Staff
Muriel Shurr

Appendix II

Long Term Care Data Task Force

Chairperson
Joan F. Van Nostrand
National Center for Health Statistics

Members
Thomas Davis, Ph.D.
Federal Council on the Aging

Burton Dunlop, Ph.D.
Abt Associates

Charles Fisher
Health Care Financing Administration

Daniel J. Foley
National Center for Health Statistics

Donald Fowles
Administration on Aging

Howard Goldman, M.D.
National Institute of Mental Health

Philip Jones
National Association of Counties

Gregory K. Spencer, Ph.D.
Bureau of the Census

Richard Strauss
Medicus Systems

Staff
Muriel Shurr
Federal Council on the Aging

The Federal Council on the Aging

Chairman

Rev. Msgr. Charles J. Fahey
Director, All-University Gerontology Center
Fordham University, New York, NY

Cyril H. Carpenter
President, Minnesota Farmer's Union
St. Paul, MN

Jacob Clayman
President, National Council of Senior Citizens
Washington, D.C.

Mrs. Fannie B. Dorsey
Director, Division for Aging Services
State Agency on Aging
Frankfort, KY

Aaron E. Henry, Phar.D.
Chairman, Board of Directors
National Caucus on the Black Aged

Mrs. Shimeji Kanazawa
Executive Office on Aging
Office of the Governor
Honolulu, HI

Mrs. Mary A. Marshall
Member, House of Delegates
Commonwealth of Virginia
Richmond, VA

John B. Martin
Legislative Consultant
American Association of Retired Persons/National Retired Teachers Association
Washington, D.C.

Rev. Walter L. Moffett
Director, Nez Perce Tribal Housing Authority
Kamiah, Idaho

Mary C. Mulvey, Ed. D.
President, National Senior Citizens Education and Research Center
Providence, RI

Bernice L. Neugarten, Ph.D.
Professor of Education
Northwestern University
Chicago, IL

Jean J. Perdue, M.D.
Medical Director
Office of Health Services
Department of Human Services
Miami, FL

James T. Sykes
Director, Public Service
Wisconsin Cheeseman
Madison, WI

Fernando M. Torres-Gil, Ph.D.
Gerontology Center
University of Southern California
Los Angeles, CA

Wesley C. Uhlman
Attorney at Law
Inslee, Best, Chapin, Uhlman & Doezie
Seattle, WA

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